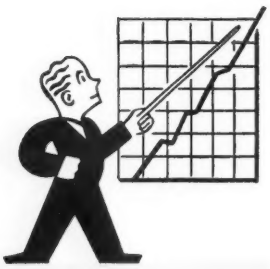
THE CANADIAN HOSPITAL

OFFICIAL JOURNAL
CANADIAN HOSPITAL COUNCIL

MAY, 1948

RECORD-BREAKING Number of Patients..

What Does It Do To Your Laundry?



Under trying conditions of recent years, the nation's hospitals have been caring for more people than ever before. This record-breaking number of patients naturally strains capacity of every hospital department.

The laundry, upon which all other departments depend for proper functioning, is especially burdened. It has had to meet increased demands from *every* department; has had to operate far beyond planned capacity. That's why hospital executives should check the laundry NOW . . . determine whether present equipment and methods are producing the increased volume *efficiently, at lowest cost.*

Our Laundry Advisor will gladly make a thorough survey of your laundry and report his findings to you. Write us today.

Modern NURSES' UNIFORM PRESS UNIT
for completely machine-finishing uniforms at a high rate of speed.

The CANADIAN LAUNDRY MACHINERY COMPANY
47-93 STERLING ROAD, TORONTO 3, ONT.

EMERGENCY ROOMS

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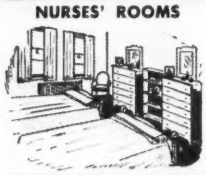
NURSES' ROOMS



More Linens

KITCHENS

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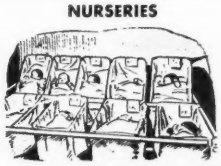
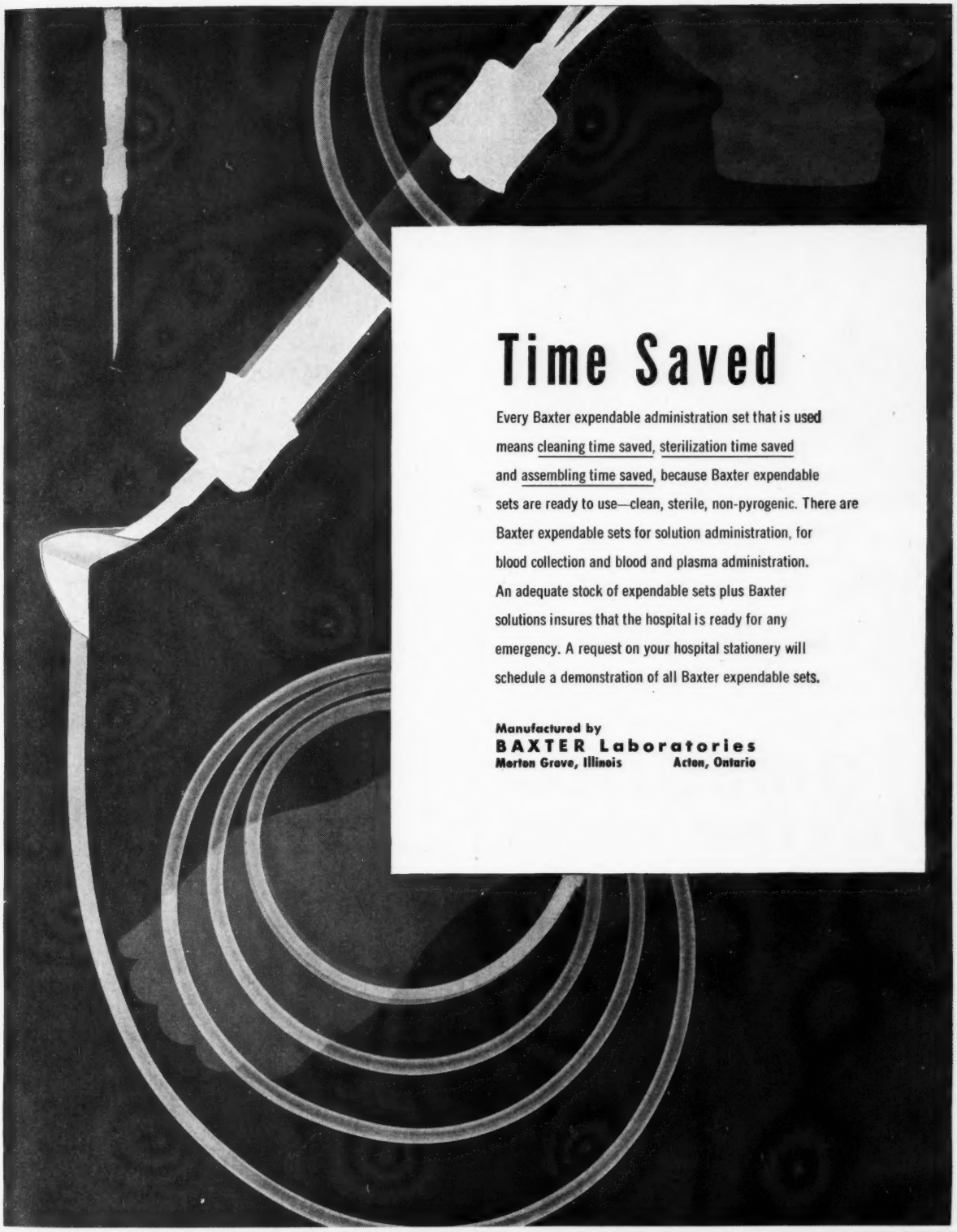
DINING ROOMS

More Linens

NURSERIES



More Linens



Time Saved

Every Baxter expendable administration set that is used means cleaning time saved, sterilization time saved and assembling time saved, because Baxter expendable sets are ready to use—clean, sterile, non-pyrogenic. There are Baxter expendable sets for solution administration, for blood collection and blood and plasma administration. An adequate stock of expendable sets plus Baxter solutions insures that the hospital is ready for any emergency. A request on your hospital stationery will schedule a demonstration of all Baxter expendable sets.

Manufactured by
BAXTER Laboratories
Morton Grove, Illinois **Acton, Ontario**

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TORONTO
MONTREAL · WINNIPEG · CALGARY · VANCOUVER

Contents

Vol. 25 No. 5

Canadian Hospital Council

The Federation of Hospital Associations in Canada in co-operation with the Federal and Provincial Governments and the Canadian Medical Association

CHARLES A. EDWARDS, Business Manager
The Canadian Hospital, 57 Bloor St. West, Toronto 5

EDITORIAL OFFICES: 280 BLOOR ST. WEST, TORONTO 5, ONT.

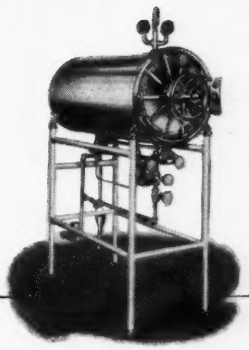
CCAB

BNA

Subscription Price in Canada, United States, Great Britain and Foreign, $3.00 per year. Additional subscriptions to same hospital, each $1.50.

Authorized as Second Class Mail, Post Office Department, Ottawa. The Canadian Hospital is published monthly by The Canadian Hospital Council, 57 Bloor Street West, Toronto 5.

Scanlan-Morris A420s Pressure Dressing Autoclave recessed in wall.



Scanlan-Morris A420s Pressure Dressing Autoclave

For authentic information on

STERILIZERS FOR HOSPITALS

Get Scanlan-Morris Technical Data

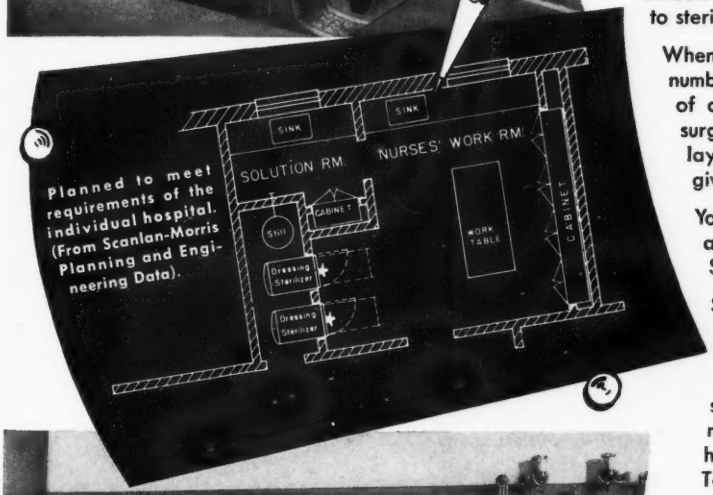
Which will serve best—exposed autoclaves, recessed autoclaves, or recessed 2-door autoclaves (from unsterile to sterile room)?

When planning new hospitals, any estimate of the number, sizes and types of sterilizers required should, of course, be based on bed capacity, amount of surgery and obstetrics to be done, and the general layout of the building. Consideration should also be given to possible future additions to the hospital.

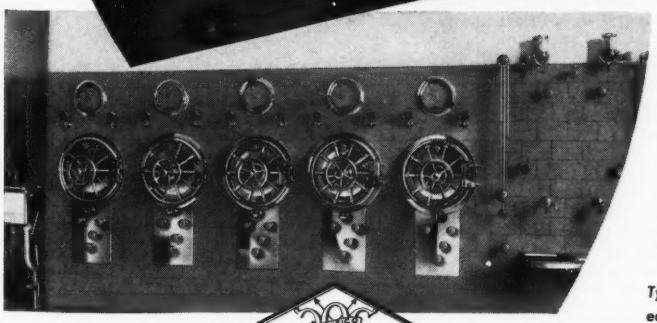
You will find much helpful information in the Planning and Engineering Data section of the catalog of Scanlan-Morris Sterilizers.

Scanlan-Morris sterilizing equipment is used exclusively not only in some of the largest hospitals but also in many smaller institutions. More than 40 years' experience in manufacturing and installing sterilizers and other major hospital equipment, and in contacting superintendents, surgeons, hospital engineers and architects, qualify our Technical Sales Service Department to supply valuable data and assistance in proper planning for sterilizers. This department will gladly supply complete engineering data, suggestions and recommendations upon receipt of estimated requirements and a set of floor plans or a sketch of the proposed building. This service is available without obligation.

Mail the coupon for the latest catalogs.



Planned to meet requirements of the individual hospital. (From Scanlan-Morris Planning and Engineering Data).



Typical sterilizing room in a 3000-bed hospital completely equipped with Scanlan-Morris sterilizing apparatus.

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OXYGEN COMPANY OF CANADA LIMITED,
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Send: ☐ Catalog and Planning Data on Sterilizers;
☐ Catalog of Surgical Lights.

(Please attach professional card or letterhead)

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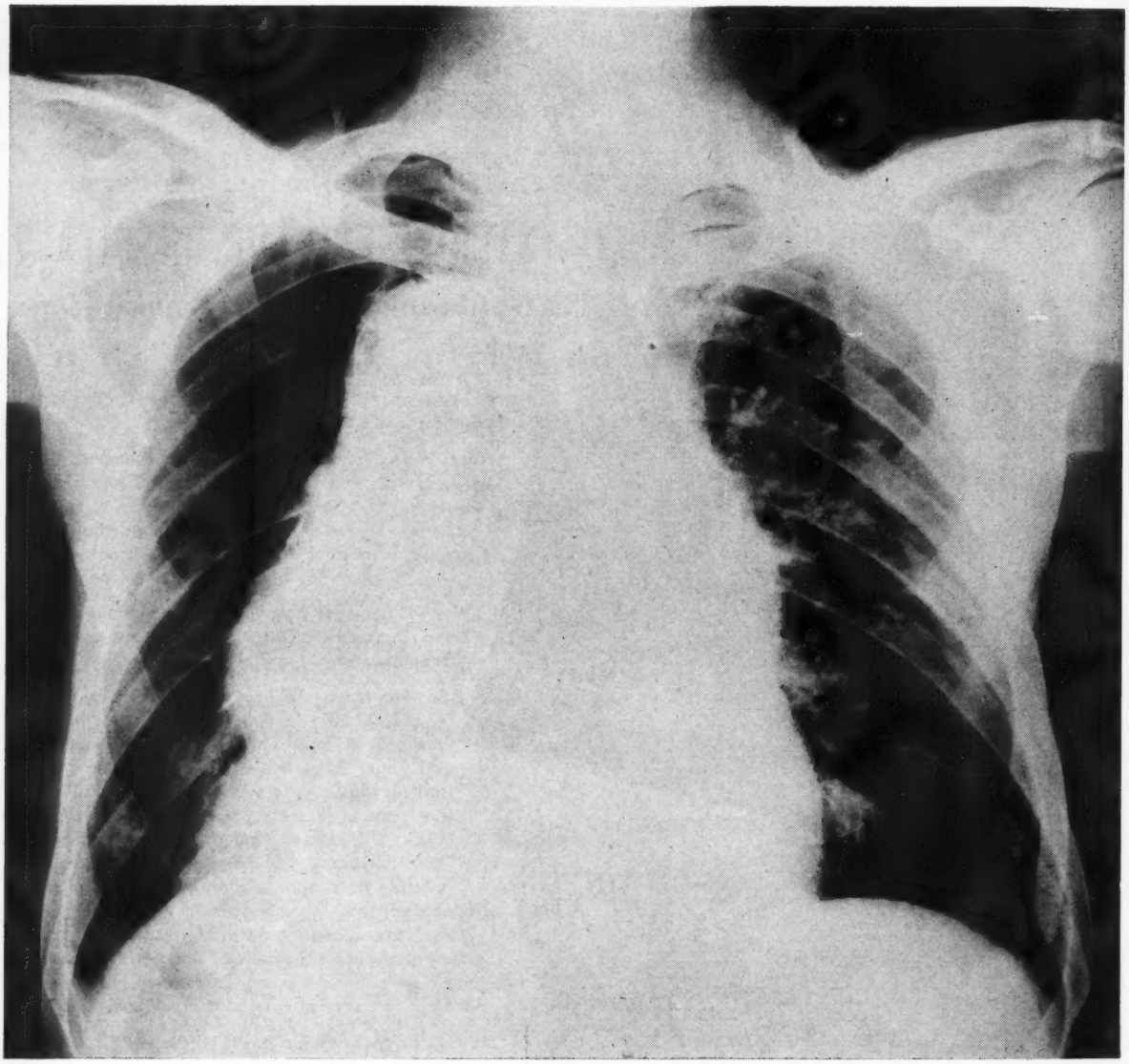
eyes *that see into the*



With the eyes of x-ray, the radiologist looks deep into the secrets of the heart. From position, size and contour, from calcification and from abnormal motion, he makes his skilled interpretation. But still there are secrets.

Will the future reveal them? In x-ray, as elsewhere, progress walks with the leader. What makes a leader? Is it size? General Electric X-Ray Corporation is the world's largest manufacturer of x-ray equipment. Achievement? From G.E. came the Coolidge tube, the oil-immersed tube-transformer, the million-volt x-ray therapy unit.

Age? Tradition? Experience? General Electric X-Ray has built fine x-ray apparatus for half a century. Research? Vision? In the General Electric Research Laboratory the 100-million-volt Betatron probes the heart of the electron.

What does General Electric leadership mean to you? It is your assurance that under the G-E emblem is the finest x-ray apparatus you can own.

heart

New G-E Centralinear Control—Type 8—for 200 ma x-ray units

You are looking at the new General Electric Centralinear control for the KX-11 double tube installation and the Model 33 table. Finished in pearl grey and black, it is the finest panel-type control in the 200 ma class.

Simple to operate. The operator does little more than push the milliampere technic button and set the kvp dial. Adjustments which formerly were hand set, the Type 8 Control now makes automatically.

Economical. By reducing errors, the Type 8 saves you money. You waste less film. You make fewer costly retakes. And for economy *plus*, protective features built into the control lengthen the life of Kenotron and x-ray tubes.

Dependable. G-E parts are x-ray parts, specially made for what they are to do. G-E design is as simple as engineering skill can make it. That is why General Electric X-Ray apparatus stays on the job through heavy patient traffic.

These are just a few of the advantages Type 8 brings you. You'll like the push-button control. Buttons are Lucite and when you push them, they *lock in* and *light up!* For details on the Type 8 write to General Electric X-Ray Corporation, Dept. E-29, 4855 McGeoch Ave., Milwaukee 14, Wisc.

GENERAL ELECTRIC
X-RAY

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MICHAEL REESE SERUMS and PLASMA

Michael Reese Serums and Plasma products are manufactured in a Government licensed laboratory. Sterility and freedom from reaction are guaranteed by exhaustive laboratory tests.

ANTI-RH BLOOD TYPING SERUM

Anti-Rh blood typing serum is prepared from the serum of human beings sensitized to the Rh factor. The technique of preparation and maintenance of sterility fulfil all the requirements of the National Institute of Health.

- Now available for routine clinical tests — of particular importance in obstetrical practice.
- Supplied in two cc. and five cc. sizes.

BLOOD GROUPING SERUMS

- For determining Anti-A or Anti-B blood groups. Each unit package of Michael Reese serum contains two bottles: one of Anti-A blood grouping serum and one of Anti-B blood grouping serum.
- Supplied in two cc. and five cc. sizes.

MICHAEL REESE NORMAL HUMAN PLASMA NOW IRRADIATED

Ultraviolet Irradiation of Human Plasma to Control Homologous Serum Jaundice.

UNDILUTED—300 cc. Normal Human Plasma, representing 250 cc. pooled original plasma. (500 cc. of whole blood.)

60 cc. Normal Human Plasma (Pediatric Unit), representing 50 cc. pooled original plasma.

ADMINISTRATION SET—Sterile Administration Set, complete with stainless steel mesh filter.

DILUTED—300 cc. Normal Human Plasma, representing 250 cc. pooled original plasma (500 cc. of whole blood), diluted with 250 cc. isotonic solution of sodium chloride.

DRIED PLASMA—300 cc. Dried Human Plasma, representing 250 cc. pooled original plasma. Supplied complete with distilled water and reconstitution set. Represents 500 cc. whole blood per unit.

THE J. F. HARTZ CO., LIMITED

1434 McGill College Ave. MONTREAL
301 Barrington St. HALIFAX
32-34 Grenville St. TORONTO

Across the Desk

By C. A. E.

C. A. Dunham Co. Promotion

The C. A. Dunham Co. Limited, announces the promotion of Mr. M. C. Bailey to the position of manager of its Toronto Sales Office after serving as acting manager during the past year. Mr. Bailey was promoting the sale of Dunham products in the Toronto area before joining the R.C.A.F. and after receiving his discharge, he returned to his former position in the Sales Department.

* * * *

New Film on Floor Maintenance

A new 16 mm. sound motion picture, "Scientific Floor Maintenance", has just been announced by Huntington Laboratories, Inc. It will be shown to the staff of any school, hospital, industry or institution on request. It illustrates the latest and most economical methods of floor maintenance and it is shown without cost or obligation. Many cleaning problems presented by modern floor materials are answered, and maintenance men quickly learn the best ways to protect and preserve expensive floors and floor coverings.

This film is the result of 27 years study and experience with varied conditions and problems, and demonstrates safe methods of cleaning, protecting and beautifying flooring material. A free showing may be arranged by writing to Huntington Laboratories of Canada Limited, Toronto.

* * * *

Explosion-proof Electrical Equipment

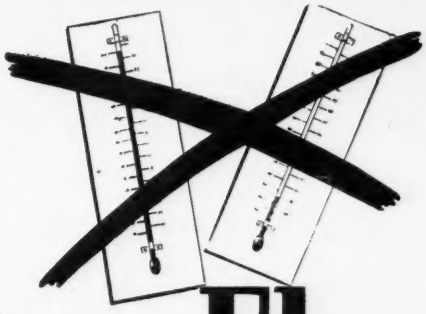
In conforming with recommendations of the National Fire Protective Association in regard to the hazards of explosive vapours and gases as anaesthetics, Crouse-Hinds Co. of Canada, Limited, have issued a bulletin on Condulets primarily intended for use in operating and delivery rooms.

Illustrations of operating rooms are shown with identification of condulets for pilot lights, hand or elbow-operated duplex switches, plug receptacles, rocker arm foot-operated nurses' call switches, plug receptacles, grounding condulets, et cetera.

Every hospital administrator and hospital engineer should be conversant with this equipment. A copy of the bulletin will be sent on writing to Crouse-Hinds Co. of Canada Limited, 7 Labatt St., Toronto, Ont.

(Continued on page 16)

Continuous *Sub atmospheric* Steam Flow *Assures* Heat Comfort



Uncomfortable overheating and underheating in a building is avoided with Dunham Differential Heating. With this system a continuous steam flow is provided but only in amounts and at temperatures for constant heat comfort. It will meet the smallest increments of change in heat demand. Dunham Differential Heating utilizes a continuous flow of flexible steam* to maintain true heat comfort.

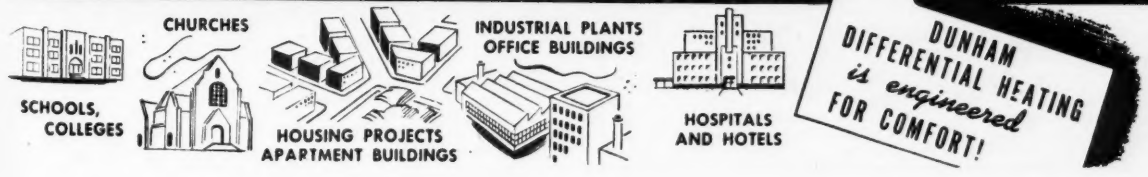
The comfort and economy of Dunham Differential Heating has been proved in buildings from coast to coast . . . hospitals, and other institutional, industrial, commercial and apartment buildings.

Dunham engineers will collaborate on installation of Dunham Differential Heating in new buildings and make recommendations for modernization of present systems. C. A. Dunham Co. Ltd., 1523 Davenport Rd., Toronto 4, Ontario. Sales Offices in Halifax, Quebec City, Montreal, Sherbrooke, Ottawa, Toronto, Hamilton, Winnipeg, Calgary and Vancouver.

***FLEXIBLE STEAM** is the most easily manageable and transportable means with which to distribute heat. It is quickly variable in temperature and volume, consequently, it can respond precisely to changes in demand for a greater or lesser flow of heat.

The DUNHAM HEATING SERVICE

THE PRIME FUNCTION OF HEAT IN A BUILDING IS TO PROVIDE COMFORT



Across the Desk

(Continued from page 12)

J. Clarke McGlashan

Appointment of J. Clarke McGlashan as General Manager of the McGlashan, Clarke Company Limited, Niagara Falls industry which is Canada's oldest flat silverware manufacturing firm, has been announced. Arthur M. Derrick, Manager, who has been associated with the firm for the past thirty years has retired.

Mr. McGlashan, third member of the McGlashan family to occupy the position of General Manager since his grandfather, the late Leonard McGlashan founded the firm in 1878, has been Secretary - Treasurer of the firm for the past ten years, serving five years of this period with the Canadian Army.

J. C. McCain is President and A. E. Davis, of the Company's Toronto office, is Vice-President in charge of Sales.

* * * *

Piping Oxygen Saves Many Steps

A hospital that recently installed an oxygen piping distribution system from a centrally located oxygen supply unit, reports that before this installation was made it was necessary to make an average of 300 oxygen deliveries per month. These deliveries involved transporting a cylinder of oxygen to the bedside, disconnecting the apparatus from the empty cylinder and attaching it to the full, and returning the empty cylinder to the storeroom. Since the piping system has been installed these deliveries have been reduced to only 7 per month. Even when an extensive oxygen piping system is not warranted, the savings and conveniences to be realized from piping oxygen to the nursery and post-anaesthesia recovery room should be investigated.

Oxygen Therapy Bulletin—Dominion Oxygen Co., Limited.

* * * *

New Tape Recorder

A Magnetic Tape Recorder Playback combining simplicity of design, high fidelity, compactness and ease of operation, has been perfected. Wholly manufactured in Canada by Utah Electronics (Canada) Limited, Longueuil, Que., this new instrument is being merchandised under the trade name of Benovoice and distributed exclusively throughout Canada and Newfoundland by Benograph, a division of Associated Screen News Limited, with head office at Montreal.

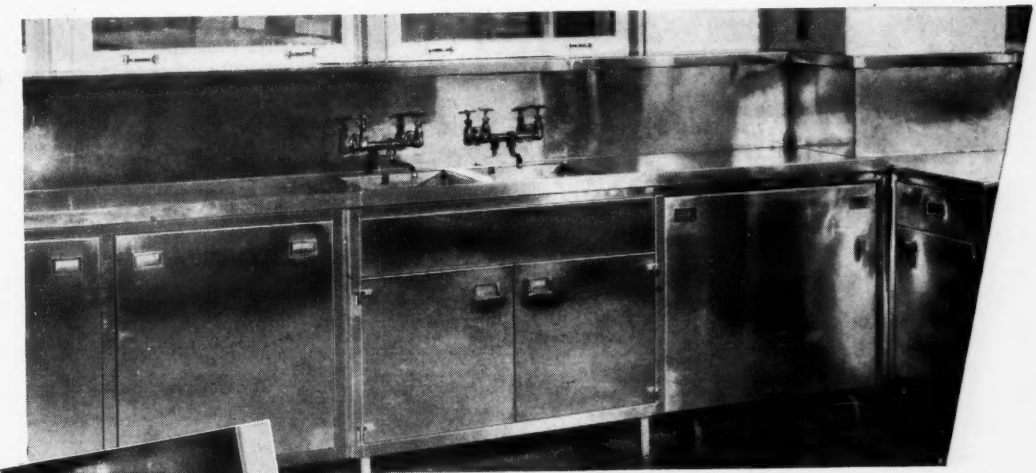
Finished in durable maroon leatherette, the light weight

(Concluded on page 20)

RUSTLESS...SOLID
WEAR RESISTANT

Monel*

FOR HOSPITAL
EQUIPMENT



The Monel diet kitchen sink and medicine cabinet illustrated, now installed in the Queen Elizabeth Hospital, Toronto, were manufactured by Metal Fabricators Ltd., Tillsonburg, Ont., who are qualified to design and fabricate hospital equipment to meet your requirements.

The outstanding metal for hospital equipment is Monel. It is stronger and tougher than structural steel. It resists heat, steam, acids and alkalies and a wide range of hospital solutions. Monel is a solid, rustless metal with no coating to chip, crack, peel off or wear away. In main or diet kitchens . . . in cafeteria and laundry . . . this attractive metal assures trouble-free, day-after-day service. For replacements, as well as for the new facilities you are planning, be sure to specify Monel for essential long-lived equipment.

* *Monel is the registered trade mark of The International Nickel Company.*

EMBLEM OF INCO SERVICE
MONEL
TRADE MARK

THE INTERNATIONAL NICKEL COMPANY OF CANADA, LIMITED. 25 KING ST. W., TORONTO

Across the Desk

(Concluded from page 16)

of the Benovoice (under .33 lbs.) assures its complete portability.

Benovoice will prove a boon in classroom teaching, speech and dramatic training, for recording medical diagnosis, personnel training and legal testimony.

Servicing of the Benovoice will be undertaken by Benograph Service Stations located at Moncton, Montreal, Winnipeg and Vancouver, plus numerous substations.

* * * *

Arthur H. Martin

W. E. Phillips, Chairman of the Board of Standard Chemical Company Limited, announces the appointment of Arthur H. Martin as President and Managing Director of that Company, succeeding K. S. Maclachlan who has retired from active business. Mr. Martin brings to the company a wide range of experience in the chemical industry, covering a period of twenty-eight years, with the Canadian Ammonia Co., Toronto, Michigan Ammonia Works, Detroit, and Canadian Industries Limited.

* * * *

Colour in Hospitals

Out of numerous conferences and exchanges of ideas with surgeons and medical specialists of many kinds, nurses, maintenance superintendents, hospital executives and employees, have come many of the practical details of a system for utilizing the power of colour through colour dynamics, as it relates to colour therapy.

The new Eye Rest Green, a true complement of the colour of blood, was developed for use in operating rooms. Sunny colours were specified for sun rooms so that they would perform their desired function even on gray and overcast days. Linen storage rooms and closets were specified in blue to enhance the whiteness of linens. Stimulating colours were planned for areas where their particular influence seemed indicated, and soothing, restful hues where a more calming effect was needed.

All of this vast wealth of material bearing on the subject of colour therapy has been classified according to the rooms of a typical institution, and presented in a booklet on *Colour Dynamics*. Write for your copy to Hobbs Glass Limited, Paint Division, London, Ont.

SEVERE BURN

(area 162 square inches)

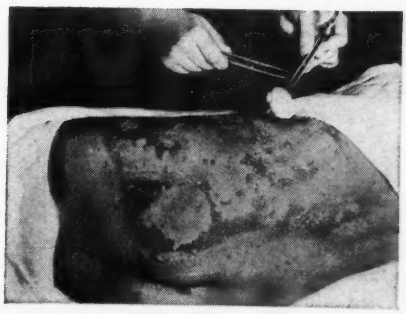


Fig. 1

Fig. 2

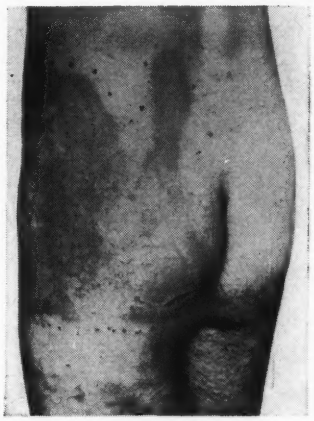


Fig. 3

A treatment using tulle gras pressure dressings and plaster fixation

CASE-HISTORY — The patient, a young man, was admitted to hospital, having been burnt by an electric blanket. The raw area measured 162 square inches. Excision of the burnt area was performed on the same day. Tulle gras (Jelonet) was applied. Fixation by Gypsona plaster of Paris bandages applied over the whole area, abdomen and thigh. The patient was given a blood transfusion.

Seven days later, the affected part was covered with thin razor grafts from both thighs and pressure dressing of Elastocrepe applied. Fixation was again secured with Gypsona plaster of Paris.

The patient was discharged to duty 7 weeks later.

The details and illustrations above are of an actual case. T. J. Smith & Nephew Ltd., Hull, England, manufacturers of "Gypsona" and "Jelonet", are privileged to publish this instance, typical of many, in which their products have been used with success in the belief that such authentic records will be of general interest.

Jelonet (tulle gras) is an open mesh gauze dressing impregnated with petroleum jelly and 1% Balsam of Peru. It is indicated as a dressing for skin grafts and in the treatment of wounds, burns, etc. Jelonet is sterilized ready for use and is supplied in 8 yd. continuous strips or in cut pieces 3¾" x 3¾".

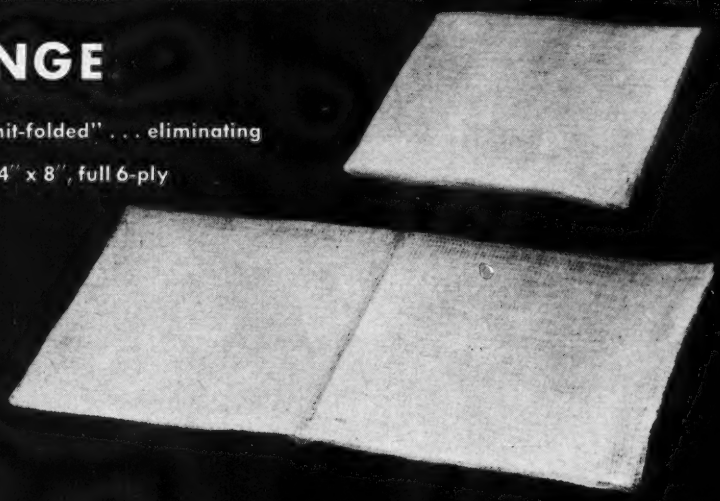
SMITH & NEPHEW LTD.
378 St. Paul Street West Montreal, Quebec

ORDINARY SPONGE

4" x 4", 12-ply sponge—when opened to 4" x 8", (6-ply)—has ends folded toward the middle leaving a gap which results in only 3-ply thickness at the centre of the sponge.

J & J SPONGE

4" x 4", 12-ply sponge is "unit-folded" . . . eliminating centre gap. When opened to 4" x 8", full 6-ply thickness assures uniform absorbency throughout the sponge.



"UNIT-FOLDED" FOR UNIFORM ABSORBENCY

Johnson & Johnson
LIMITED MONTREAL

4" x 4", 12-PLY
ALL-GAUZE SPONGES

another tribute to *DURACLAY** and the broad Crane line

● Each new picture of Crane Duraclay on the job is another tribute to the enduring *quality* of this time-tried material.

For these are not *new* installations — far from it! These Duraclay fixtures have seen years of constant usage. They have been subjected to strong acids, abrasion, extreme changes in temperature. Yet their gleaming surface remains unmarred by cracks or crazes!

Like Duraclay itself, the entire Crane hospital line is built to the highest standards of sanitation and service. And *every* hospital plumbing need — however specialized — is part of this broad Crane line.

Ask your Crane branch or plumbing contractor for full information on the Crane hospital line when you plan a new plumbing installation or modernize your present facilities.

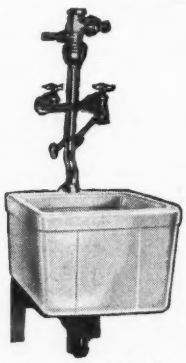
CRANE LIMITED

GENERAL OFFICE: 1170 BEAVER HALL SQUARE, MONTREAL

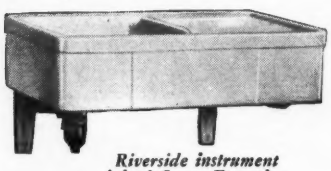
BRANCHES IN 18 CANADIAN CITIES AND NEWFOUNDLAND

↑ Crane Duraclay scrub-up sinks. Here, as in many fine, modern hospitals throughout Canada, and the United States, Duraclay fixtures have shown their ability to withstand years of the most exacting service required of any such equipment.

Pan-Walton wall-type closet with integral bedpan lugs



Serval flushing rim service sink of Crane Duraclay



Riverside instrument sink of Crane Duraclay

Hygiene patients' bath of Crane Duraclay

* *DURACLAY exceeds the rigid tests imposed on earthenware (vitreous glazed) established in Simplified Practice Recommendations R-106-41 of The National Bureau of Standards.*

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CRANE

VALVES • FITTINGS • PIPE
PLUMBING • HEATING • PUMPS

NATION-WIDE SERVICE THROUGH BRANCHES, WHOLESALERS and PLUMBING AND HEATING CONTRACTORS

Harvey Agnew, M.D., Editor

The CANADIAN HOSPITAL

Toronto, May, 1948 Vol. 25 No. 5

Obiter Dicta

Virus Diseases

IN many parts of Canada during the past few months there would seem to have been an unusual number of atypical pneumonias, frequently of a virus type. Convalescence has been quite tardy and relapses frequent.

The study of virus diseases has been actively conducted by the United States Army through the Virus and Rickettsial Division of its Medical Department Research and Graduate School. The Army has a system of watch-posts for influenza at home and abroad. The clinical symptoms of "flu" can be produced by quite a variety of infections. The diagnosis can be established by serological tests, for, within seven to ten days after the disease is contracted, sufficient antibodies have been built up to permit identification. Through these watch-posts it is hoped to be able to make early identification of the organism responsible for local and general epidemics.

A recent letter from the office of the Surgeon-General comments on the spread of Q fever to this continent. Until 1945 it was thought that Q fever, a virus infection very similar to primary atypical pneumonia, was confined to Queensland, Australia—hence its name. Blood tests on troops in Italy at that time revealed that a severe epidemic of what had been diagnosed as atypical pneumonia was actually Q fever. Further research revealed it in Greece, Syria, Palestine, and as far west as Tripoli, Spain and Portugal. Last year it was noted in Munich and recently in the United States. Accurate diagnosis is important in control, since influenza and atypical pneumonia can be transmitted from person to person, but it is fairly well established that the transmission of Q fever is always associated with animals. The source of infection is thought to be inhaled dust containing dried excreta from infected animals.

Wastage—by Misappropriation

HOSPITAL administrators are much concerned over the increasing "losses" being reported to them. These losses, like those in hotels and dining cars, have long been noted in silverware but, more recently, the wastage in linen has mounted to alarming proportions. Supervisors, housekeepers and laundry foremen, have taken unusual precautions to check supplies going through their hands but, in many cases, to little avail. In some cases the losses have been traced to certain patients; in other instances hospital employees have been responsible. Not long ago the police discovered a cache of assorted linen and supplies from several hospitals, alleged to have been collected by a special duty nurse with an eye, it is said, to setting up a private nursing home.

Now that we have restrictions and quotas on so many articles the losses in towels, diapers, and other household items are reported to be higher than ever. This may be one way of relieving the domestic shortage but adds tremendously to the purchasing problems of the hospital. Hospital authorities have hesitated to take action against patients and, when an employee was involved, have usually let the matter drop with dismissal. The situation is now such, however, that it would seem to be in the public interest that a definite charge of theft be laid against any patient or employee

so that others with a perverted sense of ownership could take warning.

A Gift with a String

HOSPITALS in Ontario were very pleased when it was announced a few weeks ago that the Provincial and Municipal payments to hospitals were to be increased (see April issue, page 46). These increased payments, while not meeting the actual cost of providing ward care, would, nevertheless, be a tremendous help in overcoming the alarming and ever-increasing gap between provincial and municipal payments and the mounting cost of providing hospital care.

Hospital boards and administrators, however, are now realizing that there is no certainty when these increases will be made. Everything is dependent upon the federal government relinquishing the amusement tax in favour of the province so that the province could levy a 20 per cent tax. Up to the time of writing, we have not noticed any rush on the part of the federal government to turn over this source of revenue, nor can we presume that this will be done without some *quid pro quo* understanding. In view of the long controversy between the federal government and some of the provinces respecting the revision of the taxing structure, it could be taken for granted that the Cabinet at Ottawa is too astute to give up one of its best cards without getting some concession in return. This impasse has held up the offer of the federal government to provide low interest loans for hospital construction, has delayed an extensive program of aid to various aspects of health development and education, and now it would seem to be delaying, perhaps *sine die* the putting into operation of this most recent provincial legislation. We note that the leader of the opposition in the Ontario House urged the Premier to declare a policy of assisting the hospitals even if it is not possible for the province to impose the 20 per cent amusement tax.

The recently enacted compulsory health insurance measure for British Columbia (see April issue, page 47), would seem to be dependent also upon the dominion government retiring from the amusement tax field.

International Congress on Mental Health

AN International Congress on Mental Health is to be held in London, England, August 11 to 21. The National Committee for Mental Hygiene (Canada) has been acting as a liaison body for this country and will be glad to send further information.

The Congress is under the patronage of the Rt. Hon. C. R. Atlee and the Rt. Hon. Anthony Eden. A wide range of topics related to mental hygiene, child psychiatry, medical psychotherapy, and relevant subjects has been arranged.

The Congress has the active support of UNESCO and of the World Health Organization, and is expected to draw delegates from many parts of the world. It is not necessary to represent any group to attend this Congress which should appeal to those interested in social work, education, psychology, and other fields concerned with human behaviour in addition to psychiatry.

If any individuals connected with the hospitals represented in the Canadian Hospital Council are planning to attend this Congress, or will be in London at that time and would like to attend, the secretary of the Canadian Hospital Council would be pleased if such individuals would write to him concerning their plans.

Progress in Reverse

BLUE Cross supporters in Chicago, and elsewhere, too, are suffering from a sudden epidemic of high blood pressure accompanied by high fever and apoplectic seizures. It all springs from the perfidy of Blue Cross's new bedfellow, the American Medical Association. After years of suspicion the A.M.A. has become very enthusiastic about voluntary hospital care plans, realizing that Blue Cross and allied developments are preventatives, not precursors, of socialized medicine.

Just when the Blue Cross and Blue Shield were really beginning to pull together in double harness, what does the A.M.A. headquarters staff, 700 strong, do but pull out of the Chicago Blue Cross Plan and join a commercial insurance company plan.

That this action has been resented is putting it mildly. Nor has it helped to advance the explanation that the Blue Cross could not guarantee its rate for the coming year while the commercial carrier could. As *Modern Hospital* has commented: "It is simply inconceivable that the A.M.A. management, after all these years, does not understand the difference between service and cash benefits—a difference which makes the insurance company's fixed rate guarantee meaningless in terms of real protection in a period of rising hospital costs."

Yet we know that this misinterpretation is one common to other than A.M.A. officials and employees. If Blue Cross were to offer merely a few dollars for each day in hospital, rather than to provide full hospital coverage irrespective of how high hospital costs and charges mount, it would be comparatively simple to estimate fairly accurately the anticipated utilization and cost to the fund. It is surprising how many groups and individuals do not realize the difference—until the hospital bills begin to pour in.

In contradistinction to the Chicago incident, when the Ontario Medical Association launched its Physicians' Services Inc. Plan (P.S.I.) a few weeks ago, the first group to enroll was the staff of the Ontario Blue Cross Plan, over 300 strong. One of the girls in this group was chosen by lot to become the first P.S.I. member.

Essential Qualifications of an Administrator

Frank R. Bradley,
M.D., LL.D., F.A.C.H.A.,
Saint Louis, Missouri.

THE essential qualifications for an administrator may possibly be stated, and in some instances accurately described; but at present it is not within the capacity of mortal man to set forth with scientific precision the underlying principle of motivation in an administrator and his basic psychology. Leadership consists of so many intense, human factors that we should not be amazed at our inability to make clear-cut definitions.

As a parallel example of a common fact not understood, may we take our almost complete lack of knowledge of the mechanics and scientific principles of the laws of life or the moving power behind it. We do not know the nature of the intelligence that controls such common, everyday occurrences as the formation of the seed of an ordinary plant or animal. What is it that enables nature to construct a perfect plant in embryo, stop its growth at almost microscopic stage, supply it with a store of food, encase it in a waterproof envelope often of a very hard texture, implement it with modes of travel to far places, and provide it with a trigger mechanism, so that after varying periods of time, often years, there is growth again. We all accept, and may take for granted, the seed as a tangible factor, but do not understand much about it. We also accept and perhaps take for granted, and may be able to demonstrate, capable administration, but our understanding of the "how" of administration is almost as vague as the beginning of life or of seed production.

Can we approach the "why" of administration by parallel thinking and by allegory? The common example of parallel thinking is the parable, and of the allegory, Bunyan's *Pilgrim's Progress* is an excellent example. The Bible uses both the parable and the allegory, particularly in a description of Christ's sayings and acts. A certain Englishman by the name of Rudyard Kipling employed both, coupled with dramatization. May we quote Kipling at this point:

Give the man who is not made
To his trade
Swords to fling and catch again,
Coins to ring and snatch again,
Men to harm and cure again,
Snakes to charm and lure again—
He'll be hurt by his own blade,
By his serpents disobeyed,
By his clumsiness betrayed,
By the people mocked to scorn—
So 'tis not with juggler born.
Pinch of dust or withered flower,
Chance-flung fruit or borrowed staff,
Serve his need and shore his power,
*Bind the spell, or loose the laugh!**

Kipling's story implies art, and administration is certainly an art. It implies further the need for careful selection and training. Otherwise, the man who is not made to his trade is by the people mocked and scorned.

The increasing complexity of administration, resulting from the growth of hospitals into health centres, demands more of the administrator than ever before. The scope of the art and sceince of hospital administration has grown by leaps and bounds, but our selection, preparation and training, of new and capable administrators has lagged far behind in both the art and science, and more particularly in the art. Whose responsibility is it to voice these facts and sentiments in such a manner that all may understand the problem of qualifications essential in an administrator so that the public, the boards of control, the schools and the universities, may become aware of the requirements and will be not only *willing to*, but *will* help the profession of hospital administration? Collectively, it is ours.

The schools and universities have recognized the need for trained administrators in the hospital field and have inaugurated courses to that end. The Joint Commission on Education has completed a three-year study, and the report of "Problems of Hospital Administration" is in the hands of most educators and preceptors of internships in hospital administration. The final publication by the Commission, "The Instructional Year in Hospital Administration", will be even more instructive.

Some of the qualifications not mentioned in either report, unless by implication, are that a capable administrator must have the physical strength and mental capacity to administer a hospital, to continue learning, and to teach his assistants and department heads. Also, as we stated previously, he must be persuasive and, above all, adaptive.*

Responsibility

As in the case of the seed, we can see some of the essential qualifications necessary for good administration. One of the most constant characteristics is responsibility. It is inescapable, and yet, such an obvious fact is frequently overlooked. Why do we not know more about the psychology and nature of responsibility? Perhaps it is because it is a fact seldom consciously stated or even admitted by the very group who select, pay and work with, the hospital administrator. Very often the administrator himself is not too conscious of the stark fact. Why? There is undoubtedly a subconscious block that prevents us from seeing too clearly disagreeable, inescapable, tedious, gnawing, sometimes dangerous things. Death is a common example.

Opening address at the First Ontario Institute for Hospital Administrators, London, Ontario, April 1948.

Dr. Bradley is Director of Barnes Hospital, a Past President of the American College of Hospital Administrators, is Professor of Hospital Administration at Washington University and a member of the Joint Commission on Education.

*Kipling, Rudyard, "But a Man Who, et cetera", Op. 15, Kim, Chapt. 11.

*The Canadian Hospital, July, 1947.

If we are reasonably normal, we tend to simply banish the thought. Another essential qualification is that the administrator be a reasonably normal individual.

How, then, can we consciously consider his inescapable responsibility without becoming paranoid or depressed? A first step is to be aware of the fact. An individual who is unaware that he is held responsible is confined in a mental cage with invisible bars. There is a sudden pressure of responsibility and he tries to escape, is bruised, hurt and surprised. He gets up, runs in another direction, and is again stopped by the invisible bars of responsibility. It would seem, then, that a simple knowledge that the bars are there might prevent our futile self-punishment.

We have said that the very groups who select, pay, and work with the administrator often do not seem to be conscious of the administrator's responsibility, and may we say, of their own. The administrator is charged with the responsibility of co-ordinating a very complex organization which has many special objectives. Co-ordination, as meant, is intended to be within the limits of the organization of the hospital, and, therefore, can in nowise relieve the governing body or the medical staff of their responsibility of leadership, in policy on one hand, and in professional care of the patient, on the other. This is an important concept, and if present on the part of the governing body and the medical staff, would protect the administrator against the all too frequent allegation that he, the administrator, assumed dictatorial powers. If the hospital is properly organized, that cannot happen. In the last analysis, the administrator is the paid executive of the governing body, and the co-worker of the professional groups who make up the staff of the hospital. Oft-times the medical staff and some of the private nursing staff are free agents, contracting with the individual private patient for their services, using the hospital as a workshop, so that, therefore, they cannot come under the direct control of the administrator.

Supervision

An essential qualification of an administrator is the ability to check the operation of his hospital in every department, in its public relations, and in its standing among hospitals. It is necessary at times for the administrator to see for himself. Supervision of employees who are unquestionably loyal and devoted to the hospital cannot be lessened or lightened because of one's own inertia, ignorance of basic facts or needs, and sometimes, just because. If one cannot lighten supervision for that group, one must doubly exercise scrutiny and supervision over those who are liable to be disloyal and those who are vicious and dishonourable. To quote Kipling's story about the British governor of Egypt:*

> "The Sheik continued, 'When crops fail it is necessary to remit taxation. Then it is a good thing, O Excellency Our Governor, that you come and see the crops which have failed, and discover that we have not lied.'
> 'Assuredly' . . . 'Assuredly', the Governor repeated, 'It is always best to see for one's self.'"

*"*The Red Foxes" in "Actions and Reactions".*

What mechanism did the Governor use to assure, inspect and supervise? He used the organization of a fox hunt as a mechanism of inspection, combining supervision with enjoyment. As he rode over the irrigation ditches of his Egyptian province, he could inspect the crops. How can you build up your tricks of the trade or art to help you see that supervision is carried out?

We have taken at random some varied facts and examples, some parallels, and some allegory, which we hope will point out the need to study the problem of hospital administration in an effort to better understand it and thereby be able to select individuals for training who can endure on the one hand, and learn on the other, the art and science of administration. We further hope that we have been able to point out some of the problems which must be studied critically, analytically, and upon which research in the field of psychology and education will go to make better leadership.

Border Crossing Simplified for A.H.A. Convention

The following letter has been sent to the institutional and personal members of the American Hospital Association, resident in Canada, concerning the convention in Atlantic City, September 20-23:

We have been advised by several Canadian members that they are experiencing difficulty with the Foreign Exchange Control Board in making, at this time, the deposit of $5.00 per person in United States funds for hotel reservations at the American Hospital Association Convention in Atlantic City this fall.

In view of this circumstance, the Association will guarantee the necessary deposit to the hotel selected and, if requested, will secure the refund of deposits already made.

Will you write on the housing form the phrase—"Deposit guaranteed by the American Hospital Association" and also advise me subsequently if you either decide not to attend or change your arrival date, specifically naming the hotel in which the reservation has been made.

Sincerely yours,
"John G. Williams"
Business Manager,
American Hospital Association.

Maritime Hospital Association Meeting

The preparation of the program is well under way for the annual meeting of the Maritime Hospital Association, which will be held in the Algonquin Hotel at beautiful St. Andrews-by-the-Sea, N.B., June 16 to 18. It is expected that many outstanding hospital administrators from across Canada and the United States will be present at this meeting and that there will also be a large attendance of trustees. One session will feature the theme "The Hospital Trustee Looks at His Job".

On June 15, immediately prior to this meeting, the Maritime Conference of the Catholic Hospital Association and the Maritime Hospital Aids Association will hold their annual conventions, concurrently, at the same hotel.

Laboratory Services ARE Essential

Poorly equipped and understaffed departments of pathology are a false economy.

Owen C. Trainor, M.D.,
Medical Superintendent,
Misericordia Hospital, Winnipeg.

PATHOLOGY is a primary requisite to the successful practice of modern scientific medicine. Since the sole purpose of the modern hospital is the study and control of disease, it is obvious that the department of pathology will be its foundation stone. As well build your house on the shifting sand as construct your hospital without regard to the character and efficiency of its department of pathology.

Of late years, it has been the fashion to divide the field of pathology into two main branches, namely, pathology and chemical pathology. The first is concerned with morbid anatomy which is the study of the growth and microscopic appearance of disease in organs and tissues while the second is concerned more particularly with the examination of material from the living patient and embraces the fields of clinical bacteriology and chemistry, haematology and serology.

In this country, except in one or two very large centres, the two divisions are combined so that the use of the term pathology hereafter will refer to the subject as a whole.

The two essential components of the laboratory of pathology are the working personnel and the equipment, including the working space. Both are important but if, for any reason, a sacrifice in either quality or quantity becomes necessary, let it not be in the first component. Better to skimp, if skimp you must, on space or equipment than to compromise on the qualifications or necessary numbers of the working staff. A competent staff may make shift with very sketchy equipment but no equipment, no matter how expensive or elaborate, can ever make up for a poorly qualified staff or for one whose numbers are insufficient to perform the work in hand. The number and composition of the laboratory staff, of course, will vary with the size and nature of the individual hospital. In every case, however, it should be comprised of two main components, the director and technical assistant.

The director must be a graduate in medicine with post-graduate training and experience in the field of pathology. It is desirable that he hold a certificate of efficiency from a recognized national certifying association, (in this country either the specialist certificate of the Royal College of Physicians and Surgeons of Canada or the certificate of the American Board of Pathology). These certificates should not be regarded as exclusive proof of proficiency, but they do guarantee that the holder has completed a definite prescribed period of training in this field under preceptors of recognized standing, a period of three years post-graduate training in a university department of pathology, plus two years practice under a qualified pathologist, and finally the passing of a comprehensive examination in the subject.

It is no longer possible to have a good standard of medical practice in a hospital without competent, properly trained pathologists, and it will not be possible to obtain such a person unless the remuneration offered is sufficient to ensure him a standard of living at least equal to his fellow practitioner of comparable training and ability.—*O.C.T.*

While the work of the clinical laboratory is directed, supervised and interpreted, by the pathologist, the actual performance is in large part delegated to another group of specially trained workers—the laboratory technicians. This work is exacting and demands high standards of accuracy and reliability, embracing as it does such diverse fields as haematology, clinical chemistry, bacteriology, parasitology and tissue pathology technique. It requires not only long and exacting special training but a standard of general education well beyond average. With the rapidly expanding demand for laboratory service in the hospital field and in medical clinics, there has developed a serious shortage in the supply of acceptably trained laboratory technical personnel. In some instances, this has led to the employment of technicians with a sketchy training. Such a trend should be strongly condemned. The whole value of laboratory examinations rests on accurate technique and to obtain accuracy and reliability, there is no substitute for adequate training. Unfortunately, the small hospital laboratory is likely to obtain a disproportionate share of superficially trained technicians and it is precisely in this field that better trained personnel is imperative.

The technician in the small hospital is largely on her own without the advantages of supervision and the assistance of skilled associates. The medical staff, in most instances without extensive or detailed knowledge in this field, are prone to call on her for interpretation, presupposing a very high degree of knowledge and experience. For these reasons, the technician in a small hospital should

Presented at the Western Institute for Hospital Administrators, Edmonton, 1947.

A.H.A. to Honour Fifty Hospital Supporters

AS a feature of the program for its 50th Anniversary Convention (Atlantic City, September 20-23) the American Hospital Association is arranging to pay special honour to a group of fifty representative men and women selected from the United States and Canada who have made outstanding contributions to hospitals.

This group to be so honoured will be representative of the many hundreds of citizens of these two countries who have rendered a devoted service to the hospital field. It is hoped that as many as possible of these individuals will be able to attend the meeting in Atlantic City in order to be present at a special ceremony—"Honour Night", Tuesday, September 21st, when honorary membership will be conferred.

Persons eligible may be members of hospital boards, workers in hospital auxiliaries or other voluntary organizations, or members of the general public who have made outstanding contributions to hospitals.

No practicing physician, employee of any hospital, or person known as a paid worker in the health field shall be eligible. The individual must be living at the time of his selection.

The term "contribution" shall be considered to include financial support but shall in no sense be confined to it. Other types of service by non-paid workers will be considered. Any provincial hospital association or hospital council, or any member of the A.H.A. may submit names for consideration. When doing so submit the following data in *triplicate*:

(a) Name
(b) Address
(c) General description of the individual, interests, et cetera.
(d) Business or occupation—name of firm—address.
(e) Complete description of the contribution(s) made by the individual. Any special dates or period.
(f) Indicate hospital(s) to which contribution(s) has been made.
(g) Give reasons—not more than 5—why you feel this individual should be considered.
(h) Other pertinent information.

All suggested names and complete information must be received by the Honour Selection Committee, American Hospital Association, 18 East Division Street, Chicago, by June 1, 1948. A carefully chosen selection committee has been appointed and, in Canada, this committee will be assisted by a sub-committee of Canadian hospital representatives generally familiar with the hospital field in Canada.

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have even better training and greater experience than her counterpart in the large city institution.

The standards of training of laboratory technicians show a marked lack of uniformity and may vary all the way from the university science graduate to a person with one or two years of high school plus a few months practice on the simpler tests in a hospital laboratory. A minimum standard is available in the form of certification by the Canadian Society of Laboratory Technologists or the registry of medical technologists of the American Society of Clinical Pathologists. Most of these qualifications demand a specific scholastic standard, a prescribed curriculum under qualified teachers and the passing of a uniform final examination. Except in cases where the laboratory director wishes to assume responsibility for the training of his own technical staff, it would be unsafe practice for a hospital to engage a technician without one or the other of these certificates.

Fortunately, the cost of equipping a hospital laboratory is not excessive. I would estimate it as under $3,000.00 except in the larger units. One finds, however, a disposition to economize on even this modest expenditure. Such tendencies are to be deprecated because lack of good working equipment reduces the staff efficiency and will usually prove to be false economy.

Two basic principles should be borne in mind when considering the financing of the clinical laboratory. First, it should be regarded as a non-profit department and not be expected to make a contribution to the operation funds of the hospital as a whole and, secondly, the laboratory should pay its own way and not become a charge on the general funds of the institution.

Two principle methods of financing in current use are the flat rate principle which utilizes the standard charge to each patient admitted irrespective of the amount of laboratory service needed. This charge is usually somewhere between $3.00 and $5.00 per patient admitted. In the other method a charge is made only for work done, using a schedule of charges for each individual examination. The method selected will depend on considerations peculiar to each locality and each individual hospital.

It is probable that in the small rural hospital neither the volume of work nor the financial resources will justify the employment of a well qualified full-time laboratory director. It is doubtful that any hospital under two hundred beds can afford to employ a full-time pathologist. Under such circumstances, it is still not desirable to dispense with such services entirely. A travelling pathologist could be engaged to serve a number of hospitals in the same area. If a competent, well-trained technician is available, periodic visits by the travelling pathologist, say once or twice a week, should provide an acceptable laboratory service to each small hospital in the district. This service might be financed by the Government or, alternatively, by the co-operative effort of all hospitals concerned.

W. C. Ryan Ill

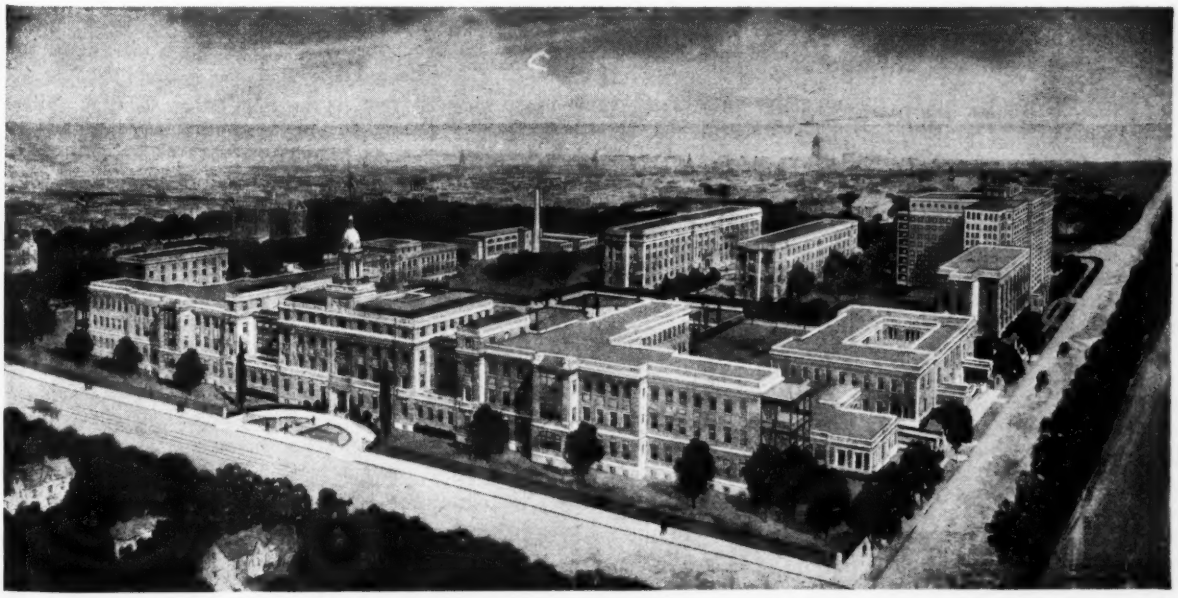
Our readers will be sorry to hear that Mr. W. C. Ryan of the Regina Grey Nuns' Hospital, has been quite ill for a number of weeks. We understand that he is showing definite improvement.

Amalgamation of Two Large Toronto Hospitals

LAST month it was announced that a merger had been negotiated which will unite the Wellesley Hospital shown above, with the Toronto General Hospital. This move is designed to place more beds under one control and to provide financial savings through unified administration. With the addition of the 275 beds at the Wellesley unit, the older hospital will now have under its jurisdiction accommodation for 1,400 patients.

The original Wellesley Hospital was founded by Dr. Herbert Bruce in 1912, and was operated as a private hospital until 1943 when, after negotiation with the City, it was converted into a public institution. The Board of Governors then decided upon an expansion program because the hospital, which had once been a private residence, could not meet the increased demand for public and semi-private care. Last year the modern six-storey wing, seen at the right (*above*), was completed, providing an additional 153 beds. However, as in the case of so many other hospitals, the Wellesley has been faced with mounting financial difficulties. In this connection, it is expected that amalgamation with the General will prove advantageous to both and to the public at large.

The Wellesley Division is situated on Homewood Place, Toronto. At the present time it has a nursing staff of 70 graduates and 132 students-in-training.



Toronto General Hospital.

As the Hospital Views Legal Problems

Walter Hatch,
Administrator, Homoeopathic Hospital of Montreal.

THIS article must not be considered as a legal guide in the strict sense of the word, but merely as observations on the legal aspects of hospital administration and procedures as practised in The Homoeopathic Hospital of Montreal.

A good starting point, and one of the basic facts concerning the care of the patient, is the *case record*, or as it is sometimes called, the case report. This poses the question "What is a case record"?

A case record is a completely recorded document of the patient's stay in hospital as related to his or her reason for hospitalization and care, and has three important factors, which are:

1. To aid in diagnosis and treatment;
2. To aid in research;
3. To comply with Government regulations which require that such a record be kept of each patient treated in hospital.

(The last factor is one from which further legal points arise.)

Operation Consent

An operation should not be performed without a written or signed *Operation Consent*. This should be signed by the patient. In the event of a patient being a minor, the father must sign the consent. The absence of the father at the time of admission does not give the mother or other next of kin the right to sign the operating consent. He must be located by telephone, wire or even cable and reply by wire or cable his consent for operation, which is filed as such in the case record. Only when the urgency of the operation will not allow time for locating the father should one deviate from this procedure, and then the consent should be signed by the medical superintendent, administrator, or other duly authorized officer of the hospital, with or without the mother's signature.

A husband may sign the consent for his wife's operation when illness prevents her signing. A wife may sign the consent for her husband likewise. A mother may sign the operation consent for her illegitimate child.

The operation consent duly completed and signed then becomes a permanent part of the case record, and under no circumstances shall it be removed from said record.

With respect to criminal abortions, or suspicions thereof, there should be two obstetricians in consultation on the case before operation.

Patients entering hospital as a result of abortion should sign a statement to the effect that the abortion occurred prior to admission to hospital.

Where a patient is admitted unconscious and an operation is shown to be essential to life, the consent must be authorized by the medical superintendent, or other officer duly authorized to grant such consent. All questions arising from the routine procedure of the operating consent should be referred immediately to the medical superintendent or administrator.

The form of consent used may vary in different hospitals. The form used in the Homoeopathic Hospital of Montreal is as shown below.

Waiver for Information

The dictionary defines the word 'waiver' as 'relinquishment of a legal right or privilege". Hence when a patient signs a waiver, he or she permits the hospital to divulge the nature of the reason for the hospitalization or treatment.

It is of utmost importance that no information be given about a patient, unless there is in the case record a signed and witnessed waiver. This waiver then becomes a permanent part of the case record and must not for any reason be removed. There are several types of waivers used, a sample form of which is as follows:

I, ...do hereby authorize The .....Hospital to provide The..... Co., with whatever medical report they may deem necessary, in my case.

Signed .....

Witness .....Date .....

The request for information of this kind is usually directed to the record department, but sometimes is forwarded to the administrator or medical superintendent.

It is interesting to note some observations of information regarding accident cases. In the event of a patient being hospitalized as a result of injuries sustained in an accident from which the patient may later take legal proceedings, he or she may naturally not be inclined to sign a waiver in favour of the legal opponent. In cases of this nature, pending Court action, the hospital is usually subpoenaed by either plaintiff or defendant to produce the case record in Court. Any duly authorized employee of the hospital may produce

CONSENT FOR OPERATION OR OTHER TREATMENT

The nature of the { illness / injury } from which .....

{ am / is } suffering has been fully explained to me and I am willing that any operation should be performed or other treatment given, which the Attending Physician or Surgeon may consider necessary.

I, hereby, permit the Attending Physician or Surgeon to have access to any previous hospital records in this Hospital or elsewhere.

Witness ..... Signed .....

Date ..... Relationship .....

said record on behalf of the hospital. The physician is usually also subpoenaed and will be asked to interpret the record to the Court.

Requests made to a nurse on the floor for information during a patient's stay in hospital should be referred to the attending physician, and in his absence to the medical superintendent or administrator. It is well to remember that the hospital must treat the record of the patient in the same confidential manner as a doctor treats the patient's record in his office.

Consent for Autopsy

Permission for post mortem examination, technically known as "Consent for Autopsy" must be given by the next of kin. A table of relationship for this purpose is as follows:

Of a husband—the wife, and vice versa;

then—

Son
Daughter
Father
Mother
Brother
Sister

The consent for autopsy becomes a part of the case record.

In Montreal a death occurring within 24 hours of admission to hospital must be reported to the Coroner. Any death as a result of an accident, regardless of the length of stay in hospital, must be reported to the coroner. In the event of sudden natural death occurring in hospital within 24 hours, the *coroner's release* may often be obtained by the physician communicating with the Crown and explaining the details of the case.

It may be well at this point to note the procedure in completing the *death certificate*. In the Homoeopathic Hospital of Montreal the physician or his resident on the case completes the death certificate and requests permission for autopsy. In some hospitals it is the duty of the admitting officer. This permission must be obtained in writing.

Up to this point the subject has dealt with matters relating directly to law. From here on matters referred to are related indirectly to law and can be considered as "Policy of Administration". The misuse, abuse or neglect of these procedures could eventuate in an infraction of the law and result in serious consequences for the hospital.

Refusal of Treatment

If a patient refuses to accede to an operation after every measure has been taken to assure the patient of the need for operation, and he or she demands discharge, the patient should sign a "Refusal of Treatment" form, and this form should be a permanent part of the case record. This policy also applies to a refusal to accept the treatment prescribed by the physician. Only under the most extenuating circumstances, and then on approval of the Administrator or Medical Superintendent, should this patient be readmitted for treatment. This procedure provides the hospital with some protection from slander and libel and possible suit for damages.

Professional Secrecy

From a legal point of view it is important that all matters pertaining to the treatment of a patient be kept absolutely secret. A nurse or any other personnel of the hospital relating facts concerning a patient or his treatment is running the risk of a libel suit against themselves as well as the hospital. This is known as a *breach of legal confidence*, as in a breach of professional confidence between doctor and patient.

As a general rule doctors cannot advise members of a family regarding venereal disease, but must report to the Health Department who deal with the situation. It is, however, lawful in the interests of the patient to give a hospital such information confidentially.

Hospital's Liability for Damages

It is well for hospital administrators to keep in mind that the hospital is invariably involved in most actions against others when the reason for such action occurred in the hospital, regardless of whether the doctor or special nurse are legally considered the agent of the patient and not the hospital.

(Continued on page 82)

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Problèmes légaux confrontant les hôpitaux

LE présent article ne doit pas être considéré comme un guide purement légal, pour le règlement des nombreuses questions légales qui peuvent surgir et auxquelles les hôpitaux doivent faire face, mais simplement comme une illustration de certaines procédures rencontrées par l'administration de l'Hôpital "Homoeopathic" de Montréal.

Dossier médical

Comme point de départ, considérons la préparation et la compilation du dossier médical.

Disons qu'il s'agit d'un document comprenant l'histoire de cas et l'ensemble des informations concernant un patient, et les raisons du séjour de ce patient à l'Hôpital.

Si ce dossier est complet et bien rédigé, il sera d'une grande assistance au médecin, lui permettant:

a) d'établir un bon diagnostic
b) de faire un choix plus judicieux des examens qui s'imposent
c) de faire la compilation des informations requises par l'Etat, touchant les malades traités dans les hôpitaux.

Interventions chirurgicales

Aucune intervention chirurgicale ne doit être pratiquée à l'Hôpital sans le consentement du malade, ce dernier étant tenu, avant l'opération, de signer une formule légale à cet effet.

Advenant le cas d'un mineur, le consentement doit être donneé par le père, et l'absence de ce dernier n'autorise pas la mère ou un parent à donner tel consentement. Il est indispensable d'atteindre le père par le téléphone, le télégraphe ou autrement, et d'exiger qu'une réponse télégraphique soit donnée, en vue de l'incorporer au dossier du futur opéré.

Il est entendu, toutefois, que quand il y a urgence, le surintendant médical ou l'administrateur général peuvent autoriser l'intervention sous leur

propre signature, même s'il n'est pas possible d'obtenir la signature de la mère.

Advenant le cas où le mari ou l'épouse serait dans l'impossibilité de signer la formule de consentement requise, le mari peut signer pour son épouse et vice-versa. Une mère est autorisée à donner son consentement pour son enfant illégitime.

Cette formule légale devient alors une pièce permanente du dossier médical, et sous aucun prétexte elle n'en sera soustraite.

Dans le cas où il existerait même un doute faisant croire à une intervention criminelle antérieure, au moins deux obstétriciens devront examiner la malade, en consultation, avant que le consentement pour intervention soit donné.

Toute patiente admise à l'Hôpital à la suite d'une tentative d'avortement doit signer une déclaration à cet effet, établissant clairement que telle intervention illégale a été faite avant son admission à l'Hôpital. Une intervention d'urgence sur un patient inconscient lors de son admission à l'Hôpital, peut être pratiquée quand il est établi par le surintendant médical ou par un médecin autorisé, que telle intervention est urgente afin de sauver la vie du patient. De toute façon, le cas doit être porté à l'attention du surintendant médical ou de l'administrateur général. La rédaction de la formule de consentement peut varier dans les différents hôpitaux; nous donnons, toutefois, celle en usage à l'Hôpital "Homoeopathic" de Montréal.

Formule de renoncement

Le patient signant cette formule renonce au droit qu'il pourrait, ou croirait avoir contre l'Hôpital, au cas où certaines informations seraient données sur la nature de sa maladie, ou les raisons de son hospitalisation. Il est donc très important de ne donner aucune information sans avoir obtenu au préalable la signature de ce document, qui, comme dans le cas de la formule précédente, deviendra partie intégrale du dossier médical. La formule suivante est admise, quoiqu'elle puisse varier dans les différents hôpitaux.

Je ....., autorise, par la présente, l'Hôpital..... à fournir à ....toutes informations jugées nécessaires sur ma ou mes maladies, ainsi que sur mon hospitalisation.

.....
signature

.....
date

Témoin:

Les demandes d'informations sont généralement transmises au service des archives médicales; il arrive, toutefois, qu'elles soient portées à l'attention du surintendant médical ou de l'administrateur général.

Les demandes d'informations sur les patients hospitalisés à la suite d'accidents de la rue, sont nombreuses. Dans les cas de cette nature, prenant pour acquit que l'accidenté ne désire pas donner d'informations à la partie adverse, il est de la plus grande importance qu'aucun renseignement ne soit fourni.

Le dossier, cependant, devra être produit à la Cour, lors de l'audition de la cause en réclamation, et un médecin sera également appelé pour en donner l'interprétation.

Toute demande d'informations faite à une infirmière en service auprès d'un malade pendant son séjour à l'Hôpital, devra être transmise au surintendant médical ou à l'administrateur général.

Autopsies

Le consentement de la famille ou de la personne autorisée à cet effet, doit être obtenu avant de pratiquer l'autopsie, et la personne signant une telle formule doit déclarer son degré de parenté, et dans l'ordre suivant:

pour un mari, la femme, ou vice-versa,
puis un fils
une fille
un père
une mère
un frère
une soeur

Cette formule doit également faire partie du dossier médical. Dans la ville de Montréal, les hôpitaux sont requis d'informer le coroner de tous décès survenus dans les vingt-quatre heures de l'admission. Libre à cet officier de permettre l'inhumation s'il est satisfait des explications fournis par le médecin traitant.

Il y a lieu, ici, de faire allusion au "certificat de décès". A l'Hôpital Homoeopathic, la procédure qui est suivi est celle-ci: le médecin traitant ou son résident prépare le certificat de décès qui contient également un consentement ou permis d'autopsie. Dans certains hôpitaux, cependant, cette procédure est du ressort du médecin attaché au bureau d'admission.

Refus de traitements

Jusqu'à maintenant, les sujets analysés étaient en rapport direct avec la loi. Nous considérerons maintenant les cas non directement couverts par les différentes lois, mais sujets à entraîner des procédures légales. *Refus de la part d'un patient* de permettre une intervention chirurgicale, ou de traitements jugés nécessaires par le médecin, et demande de congé contre l'avis du médecin.

Une formule doit, de toute nécessité, être signée par le patient et être incorporée au dossier médical. Au cas d'une nouvelle demande d'admission, le patient devra être refusé, à moins de circonstances extraordinaires, et seulement après avoir obtenu la permissions du surintendant médical ou de l'administrateur général.

(Concluded on page 78)

CONSENTEMENT pour intervention chirurgicale ou traitements divers

de la maladie (.....
Description: (.....
des blessures (.....
(.....

dont je/il souffre m'a été expliquée, et je suis consentant à ce que l'intervention chirurgicale nécessaire soit pratiquée.
Je permets, par la présente, au médecin ou chirurgien traitant, de consulter tous dossiers antérieurs, ici ou ailleurs.

.....
signature

.....
degré de parenté

Témoin.....
Date.....

George Findlay Stephens

THE hospital world suffered a great loss in the death on April 29th of Dr. George F. Stephens. His death, in his sixty-third year, was not unexpected as he had never fully recovered from a cerebral thrombosis which occurred three years ago. He resigned from his hospital post last May and had been living in Vancouver since the autumn.

Dr. Stephens had long been an outstanding figure in the hospital field and was considered one of the leading authorities in hospital administration on this continent. For five years, during the War period, he was President of the Canadian Hospital Council and, in that capacity, he guided the hospitals through a most difficult time. In 1932-33 he was President of the American Hospital Association, the first Canadian to be so honoured. It was fitting that in 1946 the American Hospital Association award of merit for exceptional service was conferred upon Dr. Stephens. He was a member of the Medical Superintendents' Club and was a charter member of the American College of Hospital Administrators.

A noted footballer in his student days, Dr. Stephens was graduated from McGill in 1907 and did post-graduate work in England and on the continent. He served with the C.A.M.C. in Great Britain and in France from 1914 until 1919 and, on his return, was appointed superintendent of the Winnipeg General Hospital. He was a tower of strength to the hospital field in that province and served in various offices, including the presidency of the Manitoba Hospital Association. In 1940 he was named superintendent of the Royal Victoria Hospital in Montreal. For many years he was on the Board of Governors of McGill University, first as a representative of the graduate society and, since 1940, as successor to the late Sir Charles Gordon.

An early advocate of the Blue Cross system of hospital care benefits, Dr. Stephens was one of the group who launched the plan in Manitoba and, on going to Montreal, did much to stimulate the final organization and setting up of the Quebec plan.

Dr. Stephens is survived by his widow, formerly Mary Sutherland of Winnipeg; a son, Graham F. Stephens of St. Louis, Missouri; and three daughters, Mrs. J. C. Poole (Lois) of Vancouver, Mrs. J. R. Lacroix (Mary) of Hamilton, and Mrs. J. A. Patterson (Joan) of Montreal. The funeral took place in Winnipeg, where Dr. Stephens was born.

Group photograph of the administrators and assistant administrators, taken after the opening session.

Over One Hundred Registrants Attend Institute at London

THE first Ontario Institute for Hospital Administrators, held in London, April 12 to 16, proved to be an unqualified success. Some 108 administrators and assistant administrators were registered at the course which was held in the Medical School of the University of Western Ontario.

This Institute was sponsored jointly by the Ontario Hospital Association and the American College of Hospital Administrators, in co-operation with the Canadian Hospital Council and the University of Western Ontario. Mr. R. Fraser Armstrong of Kingston was general chairman, Dr. Leigh J. Crozier of London was chairman of the Committee on Local Arrangements, and Dr. Leonard O. Bradley of Toronto, served as Secretary of the Committee.

Guest speakers from the United States were: Mr. Graham Davis, Battle Creek, Michigan, President of the American Hospital Association; Dr. Malcolm T. MacEachern of Chicago, American College of Surgeons; Dr. Frank R. Bradley of St. Louis, past president of the American College of Hospital Administrators, and Mr. Leonard Goudy, now of Chicago, consultant on purchasing to the American Hospital Association.

Other speakers on the program included Dr. G. E. Hall, President, University of Western Ontario; George S. Buis, Assistant Executive Secretary of the A.C.H.A.; R. Fraser Armstrong, Kingston; Edith G. Young, Ottawa; Dorothy G. Bowden, Simcoe; Miss G. D. Riddell, Ontario Department of Health; William Loveday, London; Dr. Leigh J. Crozier, London; Dr. Kenneth Gray, Toronto; A. J. Swanson, Toronto; Miss Priscilla Campbell, Chatham; W. G. Trestain, London; Dr. L. O. Bradley, Toronto; Kenneth Cross, Toronto; Dr. Fred Routley, Toronto; David W. Ogilivie, Toronto; Dr. B. H. McNeel, London; Dr. George H. Stevenson, London; Stanley W. Martin, Toronto; Harry E. LeMasurier, Toronto; Frank B. Walker, Ottawa; William Trimble, Toronto, Edith M. McDowell, London; Gordon Friesen, Kitchener; L. Gordon Bridgman, London; Dr. J. H. Fisher, London; Dr. William Caldwell, Brampton; Sr. M. St. Elizabeth, London; Dr. Harold Little, London; Dr. C. A. Harris, London.

About 200 people attended the ban-

Left: Dr. L. J. Crozier, Mr. Graham L. Davis, Dr. Harvey Agnew, Mr. J. M. Tutt and Dr. F. W. Routley. Dr. Frank Bradley of St. Louis, Mo., is in the background, hiding behind his movie camera.

quet held at the Hotel London. Dr. L. J. Crozier was toastmaster and the speaker was Dr. Harvey Agnew who gave an illustrated talk on the romance of hospital evolution.

On two afternoons the registrants were taken by bus to the different hospitals in London where excellent arrangements had been made for the demonstration of various departments and for the serving of afternoon tea.

Others who participated on the program as presiding officers were: J. McIntosh Tutt of Brantford; Lt.-Col. Gordon Ingram, London; Dr. John Neilson, Hamilton; Dr. E. S. Goddard, London; and Rev. Father Brennan of London.

The round tables, directed by Mr. Swanson, Mr. Armstrong and Dr. Crozier, proved very popular. The program was practical and covered a wide range of subjects. The delegates were loud in their praise of the quality of the addresses and discussions, and of the very complete arrangements which had been effected by the local committee. Particularly pleasing was the assistance given by the Women's Auxiliary of Victoria Hospital who served lunch each day in the nurses' residence, making it unnecessary to go back up town for the noon-day meal. Dr. Crozier had arranged for a "surprise" speaker, at each luncheon, who spoke very briefly on a subject of his choice. These speakers were Dr. MacEachern, Dr. Coffee, Priscilla Campbell (who spoke on her recent trip to Jamaica) and Mr. Nethercott.

Above: Dr. P. J. Morgan, Windsor, Mr. George Buis of Chicago and Dr. M. T. MacEachern.

Right: Dr. G. E. Hall, London, looks over the program with Dr. F. W. Routley.

To What Extent
Can We Prevent and Control CHRONIC DISEASES?

Edna Nicholson,
Director,
Central Service for the Chronically Ill,
Institute of Medicine of Chicago.

OF the five leading causes of death at the present time, the first four are chronic diseases, i.e., heart disease, cancer, cerebral haemorrhage, nephritis, and the fifth is accidents.

During the first six months of 1947, in the State of Illinois, these four chronic diseases alone accounted for more than 65 per cent of all deaths which occurred*. Experience on the Continent as a whole is remarkably consistent on this point.

The seriousness of chronic diseases is reflected not only in the extent to which they cause death but in the problems which are created by the prolonged disability which precedes death in so many cases. These problems are serious for the patient, his family, and the community. The economic and social burdens which chronic illness places upon individuals and upon society are appalling. Equally appalling is the fact that the incidence of these diseases continues to increase.

In line with the steadily increasing incidence of chronic diseases, physicians, hospitals, and others concerned with the care of the sick, are being called upon for increased attention to the care of patients suffering from these diseases. A review of the diagnostic distribution of patients in any general hospital, or those included in the practice of almost any physician, will show a large proportion of patients falling into these diagnostic groupings. Hospitals, in general, have never questioned their responsibility for diagnostic and treatment services to all patients in need of them, including those patients who are suffering from the so-called "chronic" diseases, along with the others. Their operating rooms have been as freely available to patients requiring surgery because of cancer as to those suffering from appendicitis or any other of the diseases termed "acute". Their laboratories and special service departments have been as open to the diabetic and the cardiac patient as to anyone else. Patients suffering from chronic diseases, and requiring short-term care for diagnostic or treatment purposes, have always been absorbed into the general hospital without question and without any separate identification. With respect to diagnostic service and short-term treatment, no lines have been drawn separating the acute from the chronic patient. The lines of separation have been drawn, rather, on the type of care which the patient requires.

"The time to prevent chronic invalidism is when the patient first comes to the doctor or the hospital and long before his condition has reached the stage now recognized as chronic."

Provision of Long Term Care

The question now facing general hospitals and communities everywhere is whether the patient who can no longer profit from short-term diagnostic and treatment services should remain in the general hospital when he needs long-term care. If not, where should this care be provided?

As recently as four or five years ago this question appeared to be still hanging in the balance. The chronic diseases were still step-children. Overwhelmed by the multitude of other problems pressing upon them, administrators of general hospitals could only wail, "Build special places for them—do anything you want, only get them off our door-step!" Most hospital administrators are but slightly less harassed now than they were then. They have somehow found time, however, to give a great deal of intelligent thought to this problem. The needs of the patients, the responsibilities of the general hospital, and the relationship of long-term care to other health and medical services, are rapidly being clarified. A step with far-reaching significance was taken last October, with the issuance of the statement on "Planning for the Chronically Ill" by the Joint Committee of the American Hospital Association, the American Medical Association, the American Public Health Association, and the American Public Welfare Association. It is necessary only to glance at the newspapers and popular magazines to see evidences of the interest on the part of the general public.

Professional groups, and the public, are at last wide awake to the problems of chronic illness and the need for action.

Increasing attention is being given to efforts toward prevention and control of chronic diseases, through research, professional education, and public health education. If the secrets of cancer are not uncovered within the next twenty years, it certainly will not be for want of public support and professional effort! National organizations—some of them still very new—are rapidly increasing in the various particular chronic disease fields and are pulling together the interest and support of the public for research and other professional activities essential in this field. At the same time they are promoting the health education of the general public which is essential if the chronic diseases are to be prevented or diagnosed in sufficiently early stages to permit cure or effective control. There are now national organizations concerned with heart disease, rheumatic fever, cancer, arthritis, circulatory disorders, diabetes, cerebral palsy, epilepsy, multiple sclerosis, alcoholism, hearing loss, prevention of

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From an address presented at the A.C.S. Hospital Conference in Toledo, 1948.

blindness, and other particular conditions, in addition to those concerned with infantile paralysis, tuberculosis, and mental hygiene.

New Methods of Treatment

Increased knowledge is already being reflected in better diagnosis and new methods of treatment. The forgetfulness and so-called "senility" suffered by many older people is gradually being recognized as a direct result of physical changes resulting from arteriosclerosis. We are getting away from the attitude that it is an "act of God" over which mortals cannot hope to have any control. It will probably be a great many years before the causes and methods of prevention and control of arteriosclerosis are discovered. Perhaps they never will be. But, at least, we have identified the problem and are beginning to search for the answers.

Changes in treatment methods, particularly as they affect the use of prolonged bed-rest, are already bringing changes in the extent to which patients are being kept as invalids as a result of chronic diseases. The new emphasis on enabling the patient to live with his chronic disease without being disabled by it, is already being felt. It is still too soon to measure accurately the full results of early ambulation following surgery, and of new methods of regimen for cardiac patients. But it is obvious that they are already significantly cutting down the need for prolonged care through extended periods of convalescence and sometimes permanent invalidism.

Developments in the field of physical medicine are making possible restoration of physical activities for many patients who formerly would have been accepted as permanent and hopeless invalids. Better methods of management in such conditions as peptic ulcer are cutting down invalidism from these conditions.

There are still many cases in which invalidism is a result primarily of emotional factors, superimposed on relatively minor physical damage. Recent progress in the fields of psychosomatic medicine, mental hygiene, and co-ordination of medical and social services give reason to hope that invalidism of this type can also be prevented and controlled to a much greater degree than has been true in the past.

There is an immeasurably long road still to be travelled before we have even begun an adequate program of control of the chronic diseases. Sufficient progress has already been made, however, to demonstrate very great possibilities in this field.

Practical Steps Needed

These possibilities will not fall into our hands as a result of fortunate accidents. If they are realized it will be as a result of well-planned, constructive action. This will mean continuing changes in emphasis and treatment methods in hospitals and elsewhere.

I doubt very much whether the basic problems of chronic illness can be met by a specialized approach to the chronic diseases as something apart from other phases of medical care. The time to prevent chronic invalidism is when the patient first comes to the doctor or the hospital, and long before his condition has reached the stage now recognized as chronic. New attitudes must permeate our entire approach to health promotion, preventive medicine, diagnosis, and treatment. By the time the patient has been identified as a chronic it is too late to do very much to help him. This, I think, is one of the strongest reasons why the general hospital must take major responsibility for prevention of invalidism and for rehabilitation of patients suffering from the so-called chronic diseases.

Chorley Park Becomes a Hospital for Chronic Patients

Once the home of Ontario's lieutenant-governors, and in recent years a military hospital, Chorley Park is now to be taken over by the city of Toronto and used as a hospital for incurable and chronically ill patients. According to an announcement by Mayor McCallum, the purchase price arrived at with the Dominion Government is $100,000, which amount does not cover equipment or furnishings. The Provincial Government will contribute on a fifty-fifty basis toward the cost of acquiring and furnishing the hospital, up to $2,000 per bed. It is estimated that the institution will accommodate 425 patients. Actual organization and operation of the hospital will be placed in the hands of some outside organization, rather than a board appointed by the City, and tentative discussions with the Salvation Army on this point are now under way. A two-storey cement block building to the west of the main entrance will, it is expected, be placed at the disposal of the Canadian Red Cross Society for use as a blood bank and clinic. Chorley Park will become available later in the year.

Have You Enough Nurses?

Some concrete suggestions for relieving the prevalent shortage, based on personal observations.

Ocean G. Smith,
Consulting Accountant,
Ontario Hospital Association,
Toronto, Ontario.

IF you are one of the lucky few who can answer *yes* to the above question the following observations may not interest you. If the answer is *no* the points discussed may be of some help to you.

Much has been said and written about the current shortage of nursing staff. Committees have been formed to study the problem, but no real solution has so far been discovered. In my opinion much can be done by the hospitals themselves to ease the situation. This opinion is based on experience gained in visiting most of the hospitals in the Province of Ontario. First of all I am satisfied that it is more than a question of the comparatively high salaries paid by industry and by government departments. Salaries do enter the picture but not to the extent that some writers, particularly those in the daily press, would imply.

I think that hospitals can approach the problem under four main headings and in the following order of importance:

Residences

The majority of nurses come from comfortable homes and they have every right to expect that comfortable living quarters be provided. The ideal arrangement is for each nurse to have a room of her own. This is not always possible but where two must share a room it should be by mutual agreement between the two concerned. This will avoid friction which may exist where temperaments are incompatible. Sufficient recreational facilities should be available and a comfortable living-room provided where nurses can meet their friends. No nurse will stay for any length of time in a hospital where the living quarters are inadequate or uncomfortable.

Nurse Administrator

Where there is a nurse administrator, it is important to have the right type of person. (This also applies to a director of nursing service.) One can take it for granted that she is a good nurse, but she must be more than this. She should possess a high degree of tact, sympathy and understanding; she should be one to whom nurses will not hesitate to turn, not only to discuss hospital matters affecting them, but for help and guidance in any problem affecting their own well-being. Needless to say, such a superintendent must be strict but she need not be a martinet. Hospital boards who demand these qualities in their superintendents will, I am sure, find their nursing problem diminish. Nurses will not stay where a superintendent is unfair, partial or difficult to get on with.

Meals

In spite of complaints made from time to time by ex-patients, I am satisfied that the great majority of hospitals provide good meals for both patients and staff. Where dietitians are employed, the meals are usually very attractively prepared and served. This, however, is a generalization and exceptions can be found.

Assuming that the meals are appetizing and adequate, the nurses' dining-room, on the other hand, is not always what it could be and should be. A bright, cheerful room, large enough to dispel any appearance of crowding, can do much for the morale of a nurse who has perhaps had a heavy period of operating room duty or who has been contending with a fractious patient. Do not expect the best kind of service from a nurse who has to eat her meals in a cheerless dining-room located in some obscure corner and used as such because it is not suitable for anything else.

Salaries and Perquisites

Salaries do not vary a great deal in hospitals and cities of comparable size, but there is one point which, I think, is important. When a nurse is engaged she should be quoted a gross salary including a fair value for maintenance and other perquisites; she should be told exactly how much will be deducted for board, room and laundry. Her income tax is computed on her *gross* salary and here let me remark that I think it is unwise to set a value on perquisites far below actual cost in order to keep income tax as low as possible. If you value full maintenance at only twenty dollars the nurse will do likewise, unless she decides to live out, when she will require more than that amount in lieu of maintenance. A nurse who is employed on this basis is entitled to the cash equivalent of meals and laundry while on vacation as it is part of her pay.

In conclusion, I would not like to suggest that the foregoing provides the solution to the nursing problem, but I do feel that hospitals which pay close attention to these points will be doing something tangible towards solving their own problem and indirectly that of all hospitals.

C.S.L.T. Organizes New Brunswick Branch

The Dominion Executive of the Canadian Society of Laboratory Technologists has announced the formation of a branch in New Brunswick. Some forty-five representatives from all parts of the province attended an organization meeting held at the Lancaster Hospital in Saint John. Miss Charlotte Barron of Moncton was elected president and Miss Margaret Hayes, Saint John, corresponding secretary.

Cancer Detection Clinic *Opened at* Women's College Hospital

Dr. Elise L'Esperance (left) examining a chest x-ray with Dr. Marion Hilliard, Chief-of-Staff.

OUTSTANDING among intensive efforts now being made to check the death rate from cancer in this country is the establishment of a new case-finding clinic at the Women's College Hospital in Toronto. For a nominal fee of $5.00 any woman may make an appointment to have a complete examination, including chest x-ray, urinalysis, cancer smear and other tests. The examination requires two mornings for each patient. If a clean bill of health is given, and the woman is under forty-five years of age, she returns for a check-up one year later. If she is over forty-five, examinations every six months are advised. In cases where indications of cancer are found, the patient is referred to her own doctor or to one of the cancer treatment clinics. It is not proposed to treat cancer at this clinic. The purpose of the clinic is essentially that of early case-finding.

Public appreciation of this constructive step on the part of those responsible for the new clinic was emphasized by the fact that within five days of the first announcement, every possible appointment, until the middle of September, had been filled. This service was organized by Dr. Marion Hilliard, Chief-of-Staff, and a committee of staff members under the chairmanship of Dr. Helen Milburn. Dr. Florence McConney has been appointed director. Other staff members who will give their time to this work are: Dr. Margaret MacEachern, Dr. Elizabeth Wylie, Dr. Jessie Gray and Dr. Eva MacDonald.

The clinic was formally opened on April 7th by Dr. Elise L'Esperance, founder of the Strang Cancer Prevention Clinic at Memorial Hospital, New York City. Dr. L'Esperance recommended that all women over the age of thirty have regular examinations of the type now being provided at the Women's College Hospital. Mrs. Peter Sandiford, Chairman of the Board of Trustees of the hospital, presided at the opening ceremony and among the speakers were Mayor McCallum, Dr. H. J. Cody, the Honourable Russell T. Kelley and Alderman Lamport.

At a public meeting in the Royal Ontario Museum Theatre later in the day, Dr. L'Esperance said that the medical profession must assume the responsibility of allaying fear of cancer. She indicated that the function of a detection clinic is the recognition of conditions that predispose to cancer, which if treated properly or removed promptly, may prevent the future development of cancer.

"Progress in cancer control depends on many things, and one of the most valuable is education, now so well carried on by the American and Canadian Cancer Societies," Dr. L'Esperance continued. "Another is the rapid development in clinical and laboratory research in this field in recent years. Then we have the great advancement in the modern treatment of cancer with the establishment of specialized hospitals and diagnostic clinics.

"Finally, the prevention of cancer by periodic cancer health examinations. All these agencies working together for the protection of the individual are a co-ordinated force that must in the course of events eliminate the serious character of this disease."

Dr. Eva MacDonald explains the functions of an autotechnicon to the Hon. Russell Kelley.

The Responsibility of the Administrator to the Governing Board

A. J. Swanson,
Superintendent,
Toronto Western Hospital,
Toronto, Ontario.

AT the head of the hospital, responsible for the physical plant and for every act committed therein, is the governing body. In immediate authority and responsible to the governing body is the administrator, who carries out the policy of the hospital and directs the activities as laid down by the governing body. It matters very little whether the hospital is privately or municipally owned, whether it is large or small, the function of the administrative officer is *to direct* the activities of the hospital as outlined by the board of governors. He is solely responsible to the board.

The board of governors is the only body that can institute or set up a policy for the hospital. It rests with the administrative officer, however, and through him the various committees within the hospital, such as the medical and surgical staff advisory committee, intern committee, training school committee, et cetera, to initiate and discuss policies or changes and recommend them to the board of governors. If these are approved by the board, they will then become operative within the hospital.

I should perhaps mention here a situation which is sometimes found in hospitals of various sizes and about which we hear from time to time. The governing body is usually a voluntary body of business men or appointees from the government, municipality or other groups within the fabric of the community. In their own businesses, they do not attempt to look after all the details but employ managers or departmental heads for that purpose, and they do not interfere to any extent with the functions of these departmental managers. However, in some cases, when they are appointed to the hospital board, these men feel that they are not showing a proper interest unless they interfere in some way with the operation of the hospital as carried out by the appointed administrator. They listen to the personal complaints of employees, they use their influence to secure certain concessions and, on occasions, they will have two or three departmental heads reporting directly to the board of governors and not through the administrator. This is one of the most upsetting things that can happen in any institution and is one that the administrator should take steps to correct if it becomes apparent. We do, from time to time, hear this complaint from administrators and, without exception, they all feel that it creates a most difficult situation. The administrator should be given the same freedom to run his organization as these men give the managers within their own commercial plants.

Strange as it may seem, it is a fact that in some hospitals the administrator does not attend the board meetings. I do not see how these hospitals can function efficiently, as the administrator is the liaison between all departments of the hospital and the board of governors. He should be there to report and explain any item in connection with the various departments which might come up at the board or committee meeting. For that reason, it should be a laid down rule that the administrator attend all board meetings and usually all committee meetings of the board. He cannot be familiar with the reason for certain policies which might be enunciated by the board unless he sits in on the discussions and contributes what suggestions he can from his own experience. In the well-run hospital there must be the utmost co-operation between the governing body and the administrator. Dr. MacEachern, in his book,* states that the administrator should prepare a budget for presentation to the governing body. It is a fact, however, that such budgets are useful only as a guide. With commodity prices and costs of operation fluctuating, and the great demands on the hospitals, it is almost impossible to draw up a budget that means much because we must give service irrespective of cost.

The administrator should be responsible to the board for the selection of personnel. He may delegate this duty to some other member of the staff but in the end result he is responsible for the calibre of the employees.

The administrator should take a very active part in the planning of any alterations or additions to the hospital. He is the person who should be fully familiar with the needs of the various departments, particularly the need for such expansion. He can best indicate to the board of governors or building committee the manner in which space should be allotted. The administrator should have full authority to take appropriate action on any question. If the policy of the hospital is involved or if the matter is of major importance, it should be reported to the board of governors at the earliest meeting and the action taken recorded as approved or otherwise.

The administrator should confer on every possible occasion with the chairman of his board and members of the various committees. In this way they will be familiar with what is going on and will be in a better position to discuss matters brought up at the board meetings.

From an address presented at the Maritime Institute for Hospital Administrators, 1947.

**Hospital Organization and Management.*

A Crucial Year

The general level of wholesale prices in Canada is about 90 per cent higher than at the beginning of the war. What made it difficult for hospitals was that one-third of this was compressed into 1947 and came at a time when postponed application of advanced scientific procedures had to be put into effect.—*R.F.A.*

Hospitals Concerned About

Diaper Shortage

THE shortage of diapers and diaper cloth has been giving many of our hospitals considerable concern and the supply houses do not seem to be able to promise much, if any, relief. The assumption has been that the shortage is due to the restriction of imports. However, Mr. Taylor's reply to the letter from the Canadian Hospital Council, quoted below, would indicate no reduction in domestic production and that the high cost of imported fabric had already reduced demand before the restrictions made themselves felt.

Mr. K. W. Taylor,
Assistant Deputy Minister of Finance,
Ottawa.

Dear Mr. Taylor:

Re: Diapers and diaper cloth

The situation in hospitals with respect to diapers and diaper cloth is really getting quite desperate and I am wondering if anything more can be done about it. The hospitals are now doing more obstetrics than ever before in their history, and the supplies of diapers and diaper cloth available are proving utterly inadequate. The administrators and purchasing agents tell me that the suppliers are doing what they can to distribute the available supply, but the severe quota restrictions limit drastically what they can do.

Not only is there a shortage of new material available, but the current stocks are proving very inadequate. Coupled with the increased number of patients being cared for, is the fact that stocks have been depleted during recent years and the available supply circulates through the laundry more slowly, partly on account of the increased general load and partly because of the fact that it has not been possible to keep laundry equipment up-to-date in many hospitals for some years back. An added factor since the quotas have been imposed is the "loss" of diapers and, for that matter, all kinds of linen goods. Hospitals are taking every possible precaution to protect their supplies but the wastage from unexplained sources is really alarming. The hospitals are very much concerned over the possibility of having outbreaks of intestinal trouble in the nursery, a type of situation which adds tremendously to the strain on their stocks of diapers.

Anything which you can do to improve this situation will be much appreciated.

Yours very sincerely,
"Harvey Agnew, M.D.",
Executive Secretary,
Canadian Hospital Council.

The following reply has been received from the Emergency Import Control Division, Department of Finance, Ottawa.

Dear Dr. Agnew:

I was rather surprised to see from your letter of April 9 that you are experiencing a shortage of diapers. We are well aware that the measures introduced by the Government last fall to conserve U.S. exchange might ultimately create shortages but there have been no complaints to date in this particular item.

As a result of your letter we have surveyed the situation in diapers.

Apparently domestic production of diaper material continues at approximately the same level. There is of course a smaller quantity of diapers and diaper material coming in from the U.S. as a result of the import restrictions, but our sources of information disclose that the greatly increased prices for the imported fabric —particularly of the gauze type—had already reduced demand before the restrictions made themselves felt.

Generally speaking, I am afraid that our exchange position being what it is, we shall have to carry on as best we can in the immediate future. In the meantime, we shall keep a close eye on domestic production and have already been given the verbal assurance of one or two large manufacturers that production will not be curtailed in this important item. That, I think, is the best we can do.

Yours sincerely,
"K. W. Taylor",
Assistant Deputy Minister.

Tuberculosis Control Act Amended in Manitoba

The Sanatorium Board of Manitoba will assume the functions and powers of the Manitoba Tuberculosis Control Commission on enactment of a bill to amend the tuberculosis control act, introduced by Hon. Ivan Schultz, minister of health and public welfare, during the past session.

The legislation will also have the effect of stabilizing sanatoria finances, which will put them in a position to give more efficient and economical service to patients, the minister said. Under the new arrangement, the municipal commissioner's levy, now $175,000 will be increased to $235,000 and the provincial payment (on a per diem basis for each day a patient is in a sanatorium) will be increased from 50 cents to $1.00 a day. This will mean an increase of $100,000 from the province by way of per diem grants.

The Board will be given authority to correlate all agencies in the province for the prevention of tuberculosis, to set up minimum standards for treatment in institutions, to provide consultation and supervisory service to all agencies, and to cooperate with various sanatoria in Manitoba to provide a satisfactory program for Indians.

The legislation provides that payments made by the cities and government will be paid directly to the institutions providing maintenance of patients. The money received from the municipal commissioner's levy, and any money provided by the government for the tuberculosis control program will, however, be paid directly to the Sanatorium Board, which will distributt it *pro rata* to the institutions.

M.A.R.N. Holds Annual Meeting

The Manitoba Association of Registered Nurses held its thirty-fourth annual meeting last month in Winnipeg. Miss Irene Barton who was elected president, acted as chairman and gave a review of the year's work. She stated that Manitoba was the first provincial group to reach its quota of $2,000 in the Memorial Library fund. It was reported by Miss Lillian Pettigrew, executive secretary, that 278 new members had been admitted to the association, bringing the total membership to 1,781.

A workshop for instructors will be held June 17 to 19, with Miss Francine Philo as director.

Food and Its Service

Sponsored by the Canadian Dietetic Association

Administrative and Therapeutic Dietitians

Grace A. Torrie,
Director of Dietetics,
University of Alberta Hospital,
Edmonton, Alberta.

DIETETICS is generally considered to be a relatively new profession, though the habit of eating is not a product of the "Atom Bomb Age", and dietetics is primarily concerned with this habit, for it is based on the feeding of people "in sickness and in health".

Since the beginning of the practice of medicine, food has been recognized as having an important part in the treatment of disease, and from its beginning organized nursing service has realized the patient's need of "nourishing" food and the nurse's need of "instruction in cooking". To complete the picture, we have the hospital administrator vitally concerned with the cost of running the food department, because about 20 to 25 per cent of the hospital's total budget is invested here.

The services of the dietary department are twofold. We have on one hand responsibilities chiefly scientific and concerned with normal nutrition and diet therapy; and on the other, responsibilities concerned with food administration for all patients and staff, the departmental budget, and personnel. In larger hospitals these duties are fairly well specialized and we have therapeutic dietitians and administrative dietitians.

Therapeutic Dietitians

The work of the therapeutic dietitian is the feeding of patients on special diets as prescribed by the physician or surgeon. It would make the life of a therapeutic dietitian much simpler if patients could be "fitted" to the dietary prescription of the doctor, rather than having to fit the diet to the patient. However, our food habits are usually deep seated and very difficult to change. Patients often cringe at the word "diet" feeling that they will be asked to follow a restricted, distasteful, unhappy routine. Each patient must be recognized as a distinct personality, with his own habits, likes and dislikes, all of which go to make life more interesting for him, and every effort must be made to adapt his diet to suit his own peculiar eating habits. The patient who told us that he "didn't see why they said he was on a *special* diet, when all he got to eat was ordinary food", was paying the dietitian in charge of his diet a better compliment than he realized. If it is necessary for the patient to sacrifice some of his personal food habits, he must be made to understand why it is necessary. He is entitled to a better explanation than the stock "because the doctor says you have to". It is essential also that he feel the results gained will be worth the sacrifice, or he will not stay on his diet once he is out of sight of the hospital.

Instruction: The student nurse should be given a good practical background in the planning, preparation, and serving of satisfying, attractive, food for "corrective" or "special diets". She should also acquire an understanding of the relation of corrective menus to normal diets. Basically, therapeutic diets are not some "out of this world" concoctions dreamed up by someone with a grudge against humanity, but are modifications, for example, of consistency, caloric content, or the balance of basic nutrients of the normal adequate diet.

The term "preventive medicine" highlights the necessity of teaching medical students and interns the importance of adequate nutrition as a protective factor in health.

In addition to the formal and informal teaching of nurses and medical students, if the hospital has a post graduate course for dietetic interns, their year must be planned and their work supervised, so that they get the best training possible in hospital dietetics. Because of the all-over shortage of hospital dietitians, this is an important responsibility of such a hospital.

The therapeutic dietitian is the person, too, responsible for research work and handling any special food problems that may come up, as well as keeping up to date with changes in the dietary treatment of diseases.

Administrative Dietitian

Because of the fact that such a large percentage of the hospital budget is spent in this department, dietitians have advanced to executive positions and are directly responsible to the superintendent of the hospital. Not only do they carry large financial responsibilities, but problems of health and social well being are in their hands. It is important that a hospital have a food service that is highly regarded both within the institution and in the community. Opinions about food vary considerably, but it is possible to have a food standard that will be recognized as being good.

Because of the higher food costs, good management is important. Instead of the kitchen being an "orphan" department, with one person ordering supplies, another hiring staff, and still another in charge of the actual food preparation, it should be somebody's "baby"; somebody who is trained to do the job, and whose primary interest is not nursing, or housekeeping, or anything else but the production of nutritious, well-balanced, meals at a reasonable cost. The job of food production management is not an easy one, but it will always be a challenge to the

Presented at the Western Canada Institute for Hospital Administrators and Trustees, Edmonton, 1947.

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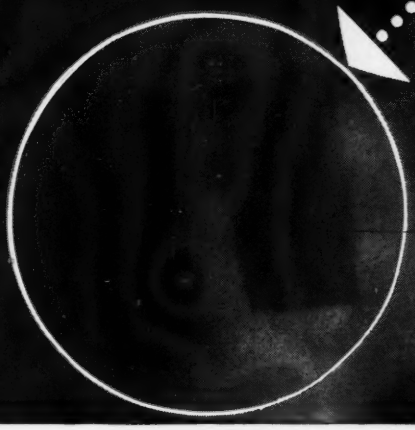

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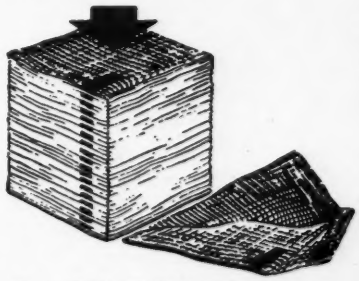

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RESEARCH TO IMPROVE TECHNIQUE . . . TO REDUCE COST

dietitian who is interested in the operation of an efficient kitchen. In order to achieve these aims, there must be a background of good organization. The work involved should be distributed systematically; there should be standards set for procedures, and there should be adequate supervision. The necessity and value of standardized recipes has been established and accepted. Cooks with years of experience will not rely upon standardized recipes because they have developed the ability to guess accurately. But the production of a uniform quality product does depend on recipes tested and standardized for amounts and methods rather than on the slip shod "pinches" of this and "handfuls" of that and "cook until done" method. The use of standardized recipes makes it comparatively easy to find the cost per serving of any food, and it is this cost per serving not the purchase price per pound or per case, that gives you the true picture of food costs.

The hiring, training and maintaining, of a working force takes a large percentage of any administrator's time, and nowhere is it more important than in the dietary department. Cooks are supposed traditionally to be "temperamental" and when one sees the awkwardness of kitchens sometimes, one cannot blame them for living up to that tradition. The inefficiency existing in some kitchens reflects the lack of basic information on the part of the people who planned them. We all know how each department puts pressure on the administrator for space, yet no unit in the hospital depends more on correct placement of equipment for economical production than does the kitchen. No housewife would stand for anyone deciding where her stove or refrigerator should go, because she believes, and rightly so, that she knows because she has to work there. Yet institutional kitchens have been known to be set up completely without any advice from the people who must produce results from them.

The purchasing of food supplies should be made to specification, on the basis of the use that is to be made of each particular item. For example, the purchase of No. 10 tins of vegetables for small units would result in unnecessary waste, and the purchase of vegetables in No. 2 tins would cause a lot of extra work in opening cans in a large unit. Not only should the size of the container be considered, but the grade or quality to be purchased should depend on where the item is to be used. One should also note the number of servings a tin, a pound, or a case, will yield. There are times when one item may be a little more expensive per unit, but will give more servings, making your cost per serving less and saving you money in the long run.

Proper storage for food once it is purchased may be a large item in food costs, and will allow you to take advantage of any offers that enable you to save money. Proper storage can also help to cut down wastage and allow you to make the best use of left-over food.

The planning of menus is an interesting part of the administrative dietitian's routine. She must take into consideration, not only what food is available, but what equipment and staff she has to work with. There would be no use planning a meal calling for all baked food if there were not enough oven space to handle it; nor would there be any use planning an elaborate meal if there were not enough staff to prepare it. She must also plan her menus so that they are up to the standard that the hospital expects.

The keeping of proper records for personnel, equipment, and foodstuffs, the repair and replacement of equipment, the maintenance of health standards for employees, are all responsibilities of the administrative dietitian.

Thomas Ritchie Ponton, M.D.

The ranks of the great leaders in hospital administration of the last generation lost one of their best-known members in the death of Dr. Thomas R. Ponton at Redlands, California, on April 2nd. He was in his 74th year and died of cerebral haemorrhage.

Dr. Ponton was born in Manitoba and was graduated from the University of Manitoba, practising for some years at Portage la Prairie. During World War I, he served in the C.A.M.C. in England and in France. On his return at the conclusion of the war, he became first assistant to Dr. Malcolm MacEachern at the Vancouver General Hospital, replacing Dr. MacEachern's former assistant who had died during the influenza epidemic. Later he served with the American College of Surgeons. He did a great deal of consulting work both on this continent and in South America and, on many occasions, took over the administration of weak hospitals and built them up. Dr. Ponton was always deeply interested in nomenclature and developed the alphabetical nomenclature, frequently known as the Ponton system, and which was later replaced by the Standard Nomenclature of Diseases and Operations. In 1939 he published the well-known book *Medical Staff in the Hospital*, a work which is still considered one of the best available on this subject. He was very keen on professional accounting, or the medical audit, and did much to develop this method of checking the efficiency of medical staff members. In later years, he was editor of *Hospital Management* and at the time of his death was carrying out his portion of the responsibility of publishing that magazine from his ranch home at Yucaipa in California.

Tom Ponton had many friends all over the world and he will long be remembered as one who had laboured hard and well to advance the field of hospital administration.

To Further Research in Heart Disease

United States and Canadian life insurance companies announce that they will give more than half a million dollars for research in heart disease during 1948. Thirty-one hospitals, medical colleges and special research clinics in eighteen states and Canada, will share $484,790 of the grants announced by the companies, and fourteen individual doctors will receive $52,600 in post-graduate fellowships. McGill University will receive a grant of $3,675 for research by Dr. Hebbel E. Hoff on the after-potentials of the heart.

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Manitoba Committee

Reports on

NURSING SURVEY

SOME time ago the Honourable Ivan Schultz, Minister of Health and Public Welfare, Manitoba, appointed a committee, under the chairmanship of Judge J. M. George of Morden, for the purpose of enquiring into the training and supply of nurses for rural hospitals in that province. During the course of the survey it became evident that any nursing shortage in rural hospitals was only part of the shortage existing in all institutions. Therefore, the committee found it necessary to include in its report data pertaining to other fields of nursing. A preliminary report of the committee's findings has been submitted recently to the Minister. The summary and recommendations of this report are as follows:

1. Public hospitals as a group, both rural and urban, are unable to procure sufficient graduate nurses to meet their estimated requirements which are placed at 636 including staff nurses, supervisors, matrons, et cetera. These institutions estimated their shortage in September, 1947, as 197 graduate nurses, which includes staff nurses, supervisors and matrons. In January, 1948, the shortage reported was somewhat less than this figure, but it is impossible to know whether this represents any real trend toward improvement.

New hospitals to open during 1948 will require at least 10 graduate nurses.

The Manitoba Department of Health and Public Welfare can immediately use at least 15 graduate nurses.

Registered nurses doing private duty are insufficient in number to cope with the demand.

Total shortage of graduate nurses in the fields surveyed may be somewhere between 350 and 400.

Shortage of practical nurses in these hospitals is reported as 125 in September, 1947. For private duty work the supply of practical nurses is less than the demand, judging from the information given by the Nurses' Registry.

Organizations, other than those mentioned above, employing graduate nurses, were not investigated.

2. An insufficient number of nurses are registering in Manitoba to make up for the wastage in the profession, and at the same time meet the increasing demand for nursing services. In 1945 there were 334 nurses newly registered and 264 removed from the register. In 1946 there were 318 nurses newly registered and 167 removed from the register. The nurses graduating from the schools in Manitoba in 1945 and 1946 were, however, only 237 and 242 respectively.

3. Nurse training schools can accommodate more student nurses. As at September, 1947, the first year class for nurses in all the training schools could accommodate approximately 60 more students. This represents an increase of about 17 per cent but even this increase would hardly meet the demands under present conditions.

4. Students in high schools have insufficient information regarding the opportunities in the nursing field. The Department of Education reports that in June, 1946, there were 1,399 female students in Grade XI and 620 in Grade XII. A questionnaire circulated among the girls in a sample group of high schools, indicated that 60 per cent were interested and requested more information about the nursing profession.

5. A certain number of young women who might be interested in the nursing profession require financial assistance. Judging from the enquiries made by the Committee, this group has insufficient information regarding the bursaries which are available.

Recommendations

1. Provide for an increase in the number of students in the nurse training schools which now exist. This might be done by integrating the small rural hospitals into the training scheme so that a student nurse would receive some of her experience in a rural hospital. This would provide a steady flow of student nurses through a rural hospital, on a rotation basis. This proposal is being studied by the Manitoba Association of Registered Nurses.

2. Provide for an organized plan to interest young women in the nursing profession. This may be done by the Manitoba Hospital Association directly or indirectly through their regional councils who would conduct a recruiting campaign in their own immediate district, similar to the plan that was followed recently in Southern Manitoba, and that the Executive of the Association forward to each of the said hospitals, an outline of the procedure to be followed, and that they contact all of the high schools in their district, either by a member of their Board or through the Superintendent, or both, leaving with the student nurses a questionnaire to be completed and returned, and that each hospital Board contact its local ladies' Hospital Aid for the purpose of seeking their co-operation, and that the Manitoba Hospital Association confer with the Manitoba Association of Registered Nurses with regard to the information that should be given to the prospective students, during such a campaign.

This proposal has been placed before the Manitoba Hospital Association for their consideration.

3. That the Minister of Health and Public Welfare provide the schools of nursing and the Manitoba Association of Registered Nurses with information regarding bursaries so that such information can be made available to applicants at training schools and included in the calendar or syllabus distributed by any training school.

4. That further study be made of the possibility of establishing a retirement scheme for nurses in hospitals.

With the Hospitals in Britain

By "LONDONER"

C. E. A. Bedwell

Dear Mr. Editor:

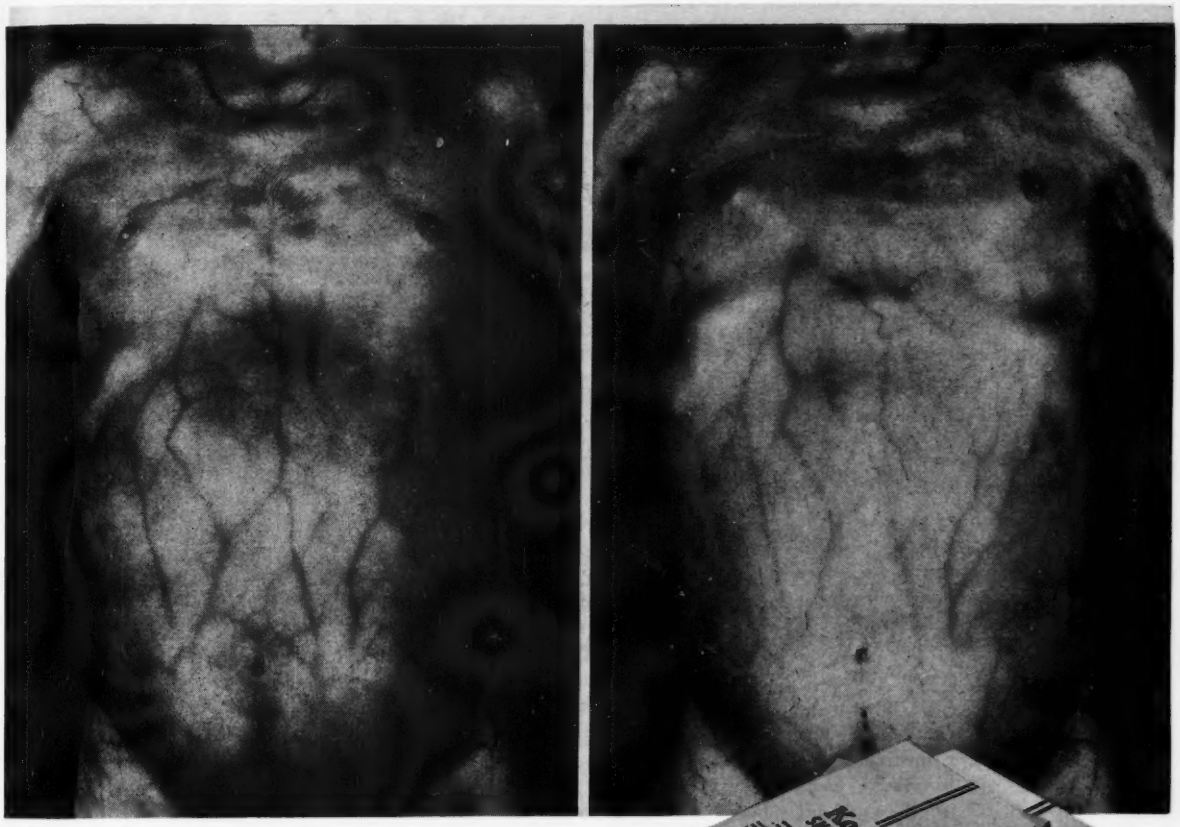
From time to time reference has been made in these pages (July, 1945 and April, 1946), to the increase of the employment of speech therapists. There has been a considerable demand for their services on the part of education authorities and at present there is not a sufficient number to satisfy it. While the training and work has developed under hospital auspices with the guidance of medical men, it is recognized that the child with a speech defect is one of those physically handicapped, who, by the comprehensive education act passed in 1944, became the direct responsibility of the Ministry of Education. As in other types of handicap, it has been found necessary to provide residential accommodation, as some of the children with speech defects need more treatment than can be given by occasional attendance at day school.

Moor House School, which has been secured by private initiative for this purpose, was the former residence of Mr. Clutton Brock and so starts with the tradition of an association with language and literature. It stands in a beautiful part of Surrey, in six and a half acres of gardens and parkland, conveniently near to a little station halt at Hurst Green, reminiscent of those familiar in Canada. At the school can be received twenty-eight children suffering from various speech defects arising from conditions such as aphasia, post-operative cleft-palate speech and mild forms of cerebral palsy. At present all the children are under nine years of age, but it is clear that the time will come for older children, if only for some of those who are not sufficiently far advanced as they grow older to take their place in normal life. The school is the only one of its kind in Great Britain, and there is said to be only one other in the world. The children have come from far and wide, and included at the time of my visit one little fellow who had been interned in Hong Kong. Walking around the classrooms, where there was a wide variety of occupations, I could not fail to be impressed with the brightness of the children's expressions, even when their faces were in repose. It was such a striking contrast to the dullness so often associated with any lack of mental development.

Increasing Demand for Speech Therapists

Under the direction of the same principal, Mrs. Hudson Smith, is a training school for supplying qualified speech therapists needed in all parts of the country. The future of this and other schools is undetermined, at the present time, owing to the possible repercussions of the national health service act upon the hospitals. The hospitals provide the material upon which the students receive some of their practical training, and in the case of Moor House students there is an association between its governing body and the committee of one of the nervous disease hospitals. Similarly, other schools which are private undertakings carried on by their principals, obtain some of the practical experience for their pupils in other hospitals. The relationship with the hospitals, however, is not of primary importance. It is much more serious that this valuable educational work should be so dependent upon individuals rather than possess some permanent basis. The Ministry of Education has shown its interest and the Minister last year formally opened the Moor House School. No one can have any doubt about the value of the undertaking. There is no need, and none of the parties concerned desire, that this should become a State enterprise but there is room for the co-ordination of voluntary authorities in order to provide the speech therapists so badly needed on the staffs of the education authorities throughout the country.

Another aspect of the work at the Moor House School which is of interest, and is of considerable value to all concerned with speech defects is the research, which is being conducted under these favourable auspices with willing material. Medical specialists, with interests in particular aspects, meet together in conference from time to time to discuss the conditions and the findings of the speech therapists in the course of the work. Physicians, surgeons, psychologists, psychiatrists and others all have their contributions to make to the solution of these problems. Environment, too, may play its part, though the substitution for home influence, especially of a good mother, is a matter upon which there is much to be learned by careful observation. One thing, unfortunately, is becoming quite clear, and that is that the number of children at home, growing more handicapped for lack of treatment because it was thought that they could derive no benefit from attendance at school, is much larger than was realized until some began to receive attention. As they show progress from treatment and tuition the good news spreads and other children and their parents obtain a gleam of hope.



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Hypnotism

as a Therapeutic Agent

A review of a new book "Hypnotism Comes of Age"

IN recent weeks several references have been made in the public press to the successful use of hypnotism in childbirth by a young Canadian doctor, A. P. Magonet, a Dalhousie graduate now practising in England. It is of interest, therefore, to review an illuminating book on the subject of hypnotism by Bernard Wolfe and Raymond Rosenthal which has just come off the press.*

Hypnotism is not a new phenomenon by any means. In all probability it was the secret of the medicine man's success in primitive times. Many aspects of hypnosis were known to doctors in the ancient world. Aristotle described hypnagogic hallucinations and Plutarch related how Pyrrhus of Epirus cured cases of colic by "touching" the sufferer with his big toe.

It was a Viennese doctor, Franz Anton Mesmer, who did so much to give hypnosis a new status. True, his theory of "animal magnetism" has not stood the test of time, but his remarkable success stimulated much interest in his theories and methods. Neurotics from all over Europe flocked to his "magnetic seances" and were helped. Descriptions of the hysterical actions of his groups of patients in the 1780's reveal a power beyond belief.

In time Mesmer fell into disrepute but others made more accurate analyses of the basis of this curative influence. Count Puységur discovered how to effect artificially induced somnambulism. In 1843, James Braid, an Englishman, writing on *Neurypnology*, developed the mysticism of mesmerism into scientific hypnotism and began to use hypnosis as an anaesthetic in surgical operations.

A few years earlier a Dr. Elliotson had been under attack for suggesting its use in British hospitals. In 1841 a Dr. Ward reported a leg amputation under hypnosis and was roundly abused. A Dr. Copland sagely pronounced that "pain is a wise provision of nature, and patients ought to suffer pain while their surgeons are operating; they are all the better for it and recover better".

A French country practitioner, A. A. Liébeault, was so successful in applying hypnotic suggestion without hocus pocus or fantastic theories that Professor Bernheim of Nancy became interested and ultimately, in 1886, published his *Suggestive Therapeutics*, the first adequate scientific treatment of the subject. A few years later Freud took up the study, developed the concept of the unconscious mind and went on to formulate his methods of psychoanalytic treatment.

Hypnotism "came of age", however, with World War II. Psychiatrists in the services, studying the after effects of combat fatigue and other mental states found hypnosis to be a valuable ally. Orthodox psychoanalysis may require three or four hourly sessions a week for up to three or four years. Hypnoanalysis, on the other hand, permits much more rapid release of the unconscious mind and shortens tremendously the time required to understand and cure the individual case. In the services, where the limited number of psychiatrists and psychologists found themselves with more patients than they could handle, hypnosis resulted in many speedy and spectacular cures. Grinker and Spiegel working in Army hospitals in North Africa and at home evolved a therapy which they named "narcosynthesis". They used sodium pentothal to assist the soldier re-live the experiences back of his emotional crackup, a use of drugs already developed by J. S. Horsley in England, back in 1931, and called by him "narcoanalysis".

Hypnotherapy is now practised on an extensive scale at the Menninger Clinic, a psychiatric centre located at Topeka, Kansas.

Hypnosis in Medicine

Practitioners of hypnotic medicine have claimed good results in hysterical somnambulism, frigidity, alcoholism, kleptomania, homosexuality, anxiety neurosis and hysterical paralysis.

In the treatment of organic disease, "the types of illness that respond best are those such as asthma, eczema, stomach disorders and so on, which have a clear-cut psychosomatic basis. In general medicine, hypnosis has, of course, been used as an anaesthesia during surgical operations and childbirth labour."

With reference to its use in childbirth, the authors note that it was popular in European countries before the war, but owing to the prejudice against hypnosis in America, it was never used by obstetricians here on a large scale. "And it is doubtful that hypnosis will supplant the established anaesthetics since there are few trained hypnotists and the precedure demands a skilled operator. When hypnotic anaesthesia *has* been utilized for childbirth, it has proved extremely satisfactory; pain is done away with completely and the shock that usually follows delivery does not take place."

The authors describe in some detail the procedure of hypnosis and quote many case reports published by various investigators. They answer many of the questions regarding the subject which come to the mind of the reader. The authors are not physicians themselves and have based their material on the extensive literature on the subject, coupled with numerous interviews with leading exponents of the subject, the manuscript being carefully checked by Dr. Lewis Wolberg. The work is well documented and has an extensive bibliography.—*G.H.A.*

Man may be overwhelmed by a natural force, but he is nobler than his destroyer; for man knows that Nature has this power, while Nature knows nothing.—*Pascal.*

**"Hypnotism Comes of Age"—Its progress from Mesmer to Psychoanalysis. By Bernard Wolfe and Raymond Rosenthal. Pp. 272. $3.75. The Bobbs Merrill Company, New York; McClelland and Stewart, Toronto. 1948.*

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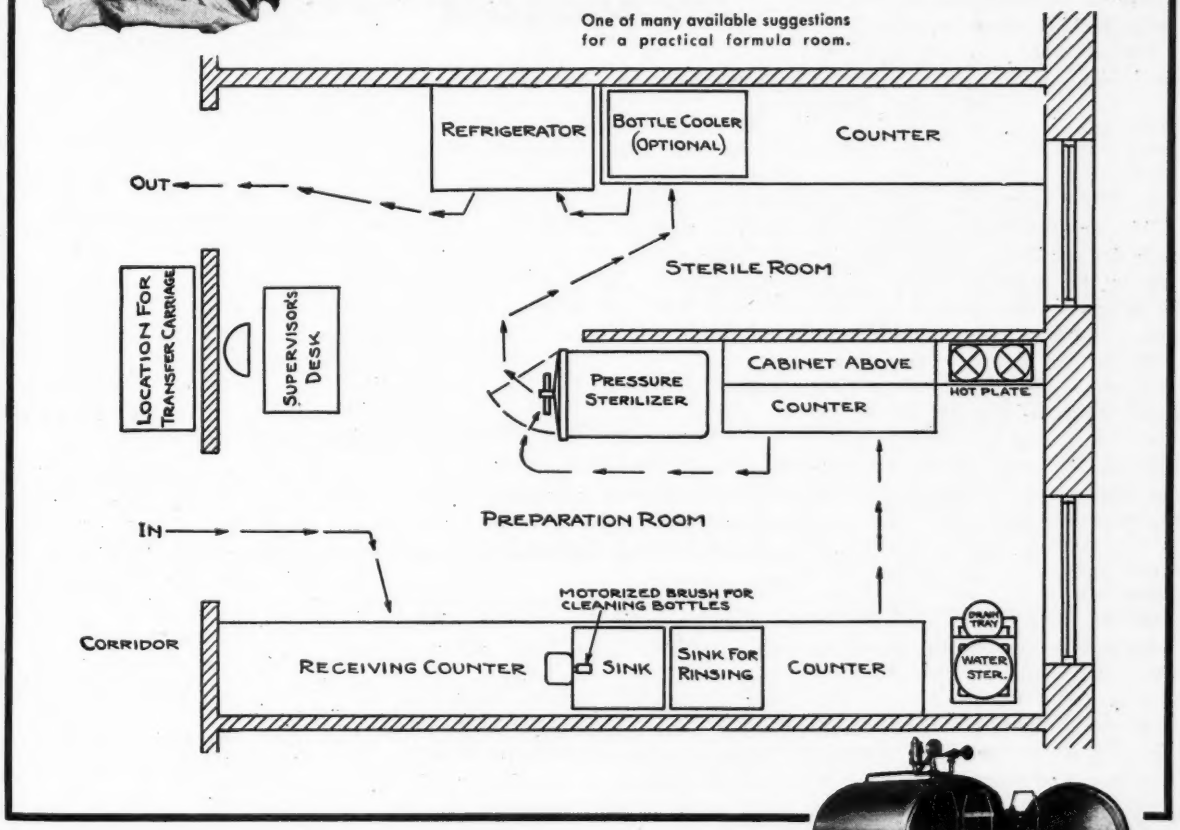

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Notes on 'Margarine

Gallup Poll Indicates 58 Per Cent Want Margarine

According to a survey made recently by the Canadian Institute of Public Opinion, a clear-cut majority of voters favour removal of the ban on the manufacture and sale of oleomargarine in Canada.

A steady decline in the number of Canadians who support the margarine ban can be seen from the following table which shows attitudes taken in three separate years, on a percentage basis.

	1943	*1947*	*Today*
Favour sale	35	45	58
Oppose sale	45	40	29
Undecided, no opinion	20	15	13

This swing in opinion has been much sharper in the towns and cities than in the farming areas. While the number in the latter group who approve the ban has remained fairly stable during the past five years, many who were "undecided" in 1943 would seem to have decided in favour of it if they have thought about it at all. The farm vote on a percentage basis in the three survey periods, can be shown thus:

	1943	*1947*	*Today*
Favour sale	25	27	34
Oppose sale	54	55	54
Undecided	21	18	12

An examination of the non-farm votes, only, indicates that exclusive of this group two-thirds of Canadians would like to see margarine on sale. In earlier years, it was the housewife who showed the keener interest in this whole problem, but today the views of men and women coincide very closely.

In the course of the latest survey, the Institute ascertained that over half the adults in Canada have never used oleomargarine and that from this group comes the greatest opposition to its sale.

Last month the margarine ban was the subject of heated debate both in the Commons and the Senate at Ottawa but there was no indication of an early decision on the part of either body.

Oleomargarine Approved by Manitoba Legislature

A motion recommending removal of the ban on manufacture, importation and sale of oleomargarine and other butter substitutes was approved by the Manitoba legislature in April. The resolution was carried after the passing of an amendment asking that the margarine question be considered by federal authorities "coincident with and as part of a general national policy of removing all duties, tariffs and embargoes which increase the dairyman's cost and/or reduce his price".

* * * *

The Coming Battle on Margarine in the United States

(The following is condensed from an article in "Trustee", a journal published by the American Hospital Association.)

For about half a century hospital budgets have been the victims of horse-and-buggy laws and regulations (U.S.A.) which impose various federal taxes and licence fees on oleomargarine. To an average 100-bed hospital today, these might well mean about $1,000 a year in addition to the cost differences between margarine and butter — perhaps a total of more than $3,000. Many states add taxes and restrictions of their own.

Discriminatory margarine taxes are not new. The first was put on by Congress in 1886. During the last war several states suspended or eased their restrictions so that many hospitals experienced the economy of margarine for the first time. However, these restrictions have since been restored.

It now seems that the long overdue turning point is about here. The last restrictive measure was added in 1931. In 1944 and 1945 proposals were studied by Congress to lift the federal taxes and licence fees. In 1946 a similar bill died in a House Committee when Congress adjourned. The present Congress has several new proposals and these have the strong backing of a now-powerful margarine lobby.

Fair tests prove that margarine matches butter on most points. The American Medical Association and the National Research Council say that fortified margarine can be substituted for butter at no nutritional disadvantage. Each pound of margarine must be fortified with 9,000 U.S.P. units of vitamin A to meet the U.S. Pure Food and Drug Administration regulations. Yet most manufacturers add 15,000 units. Most add vitamin D too. With those two additions the vitamin content of margarine and butter check closely. In addition, each yields about 3,000 calories per pound.

At this point the similarities end. Butter costs over twice as much as margarine. Margarine is 80 per cent highly refined vegetable oil; butter is 80 per cent animal fat. Both the oils and fats are produced on American farms, however.

Most packaged margarine, as it is sold over the counter, is white; butter, yellow. And here is where the hospital begins to run into inconvenience with margarine. Pure artificial colouring may be added to butter (cheese and ice cream likewise) if it appears too pale. The only cost is for the colouring matter and the labour to mix it. But if margarine, which comes bleached white, is to be coloured, the federal and state taxes begin to pile up.

If a hospital wishes to colour margarine to serve to patients and employees, it becomes, in the eyes of the federal government, a manufacturer and must pay a $600 licence fee each year. It also must pay the standard one-fourth cent per pound excise tax on uncoloured margarine. In the few states where coloured margarine can be sold, the federal excise tax amounts to ten cents per pound but there is no manufacturer's licence fee. The average 100-bed hospital uses about 9,000 pounds of butter or margarine a year.

The hospital must be cautious, also, lest it be charged by the federal government with "misrepresentation". If it is serving margarine as a separate food (not in cooked food where it loses its identity) it must

(Concluded on page 104)

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Correspondence

Electrotherapeutic Equipment

To the Editor:

It was with great interest that we perused the chapters dealing with excise tax and electrotherapeutic equipment, in the March issue of *Canadian Hospital,* (page 49).

We note in particular the extract from a letter received from the Hon. Mr. Paul Martin, Minister of National Health and Welfare, concerning electrotherapeutic equipment. Mr. Martin's statement to the contrary, this hospital was compelled to discontinue the use of our Beck-Lee short-wave Diatherm, which has been in operation for several years. We were unable to procure funds to purchase a new piece of equipment, as recommended by the Department of Transport, and there is no technician in Foam Lake who can suppress radiation to the satisfaction of the Department.

This hospital has therefore been without the services of short-wave diathermy since 10th January, 1948, and will continue to be so for some time to come as there is little likelihood that we will be in the financial position to purchase new equipment of this nature, as we are engaged in the construction of a new hospital at the present time.

When we consider our position here, it is difficult for us to reconcile ourselves to the remarks of Mr. Martin.

Yours truly,
"M. A. Williams"
Secretary-Manager,
Foam Lake Union Hospital,
Saskatchewan.

* * * *

The Supply of Nurses

To the Editor:

I have read your article (April, page 25) with great interest. It is an exposition that should make the problem very clear to everyone and forestall suggestions that seem to the proposer obvious, but with fuller knowledge are seen to be useless.

At present, the only portal to any work connected, however slightly, with nursing is either the three year course leading to registration or the nine to twelve months' course preparing for assistant general nursing duties.

The supply of the latter group will perhaps increase more rapidly as the courses become better known and being a nurse assistant seems as normal a job to consider as employment in shops and offices. At present the applicants are not very numerous.

The graduate group has limits placed at both entrance and completion. The proportion of girls who can reasonably be expected to elect nursing on graduation from high school must be approximated—this fact has had to be recognized in other countries and even in one of our own provinces.

At the other end of the scale our present society seems to approve very much earlier marriage than heretofore. While this phase lasts, the loss of the young, freely movable, full-time graduates is much greater than it was in pre-war days.

Are there some activities at present identified with nursing, and calling for the qualifications of a registered nurse, (with the variety of experience that implies) which might be handled by a group specifically trained?

Because of the tendency to early marriage, are there not young women who see only one or two years of work before marriage, after which time they plan to stay at home?

Could a well educated person of this type receive a specially designed course without operating room and obstetrical training, et cetera, but with emphasis on, say, mental hygiene and occupational therapy and be a useful person in our mental hospitals with certain groups of patients?

Do industries always need graduate nurses in the present numbers, or could some of the positions be held by first aid workers and others by people trained in personnel work?

Do we in the hospitals sometimes employ graduate nurses in technical positions which could be well done by others trained for the job, but in which the "fatal availability" of the nurse has placed her?

So far no suggestions seem to meet adequately the ever-widening gap between the annual production of graduate nurses and the increasing demand throughout the community.

There is no longer a comfortable bank account in the nursing world, from which all sorts of luxuries and extras can be supplied. The available means do not even meet the day-to-day requirements.

We have discussed at great length the importance of nurses doing nursing duties only in the hospitals. We might also discuss the importance of nurses occupying only nursing positions. Perhaps our salad days are over, and we should get down to the reality of our profession and concentrate our skills, experience and special qualities, in those situations where absolutely no substitute can be employed.

Let us make no mistake, nurses will always be sought for every kind of post, because of their amazing adaptability. Why not use nurses for the purpose for which they were trained?

Yours sincerely,
"Jean I. Masten",
Superintendent of Nurses,
The Hospital for Sick Children,
Toronto.

* * * *

A Warning to Editors

Dear Harvey:

I am suing you for $250,000 because of a blasphemous article on page 56 of the March, 1948, issue of *The Canadian Hospital* ("Mac Joins a New Fraternity"). My many admirers thing it is awful of you to carry this joke so far.

In order that I may have copies for my prosecuting lawyers, will you pleace send me about four copies of the article (—of course, there will be lots of money from the suit to pay for them).

Hope to see you soon, you old rascal.

Yours sincerely,
"Malcolm T. MacEachern"
Associate Director,
American College of Surgeons.

Health Care Plans

Ontario Blue Cross Plan Increases Benefits and Rates

Coverage for x-ray, more days hospital care, modern medications, reduced waiting period for maternity care and extension of the family contract to include children under 18, are the new benefits which the Blue Cross Plan of Ontario is extending to participants, effective July 1st, 1948.

The Plan will pay up to $25.00 each admission for x-ray if it is used in the regular course of treatment of the injury or illness for which the subscriber or dependant is receiving continuous bed care or when used in emergency hospital care immediately following an accident. (Deep therapy is not included.)

The previous maximum of 51 days hospital care is now the minimum and 10 additional days are added for each year of continuous participation to a maximum of 201 days.

Admissions to recognized chronic hospitals, not formerly covered, are now provided with a total of 51 days hospital care in all. This also applies to admissions for tuberculosis and certain nervous or mental disorders.

Modern medications such as penicillin will now be covered to a maximum of $25.00 for each admission. (The former no-limit coverage for ordinary drugs and medications remains.)

The previous 12-month waiting period for maternity care has been reduced to 10 months and the limit of 12 days has been removed. Fifty per cent of hospital charges for childbirth is paid by Blue Cross for subscribers, under the family contract, who have fulfilled the waiting-period.

The former age limit of sixteen for dependants has been extended to include those under eighteen and unmarried children between eighteen and twenty may be enrolled by the parent at the single subscription rate.

In order to absorb the higher hospital costs which have risen over 40 per cent since the Plan began, and to provide the additional benefits, new rates will be effective for all subscribers beginning July 1st, 1948. They are as follows: Single rates, standard ward, 75 cents per month, semi-private, $1.00 per month. Family rates, standard ward, $1.50 per month, semi-private, $2.00 per month.

The payment of the first subscription by the subscriber will indicate his acceptance of the new rates and the new benefits will be available only to those who are admitted to hospital on or after this acceptance. None of the new benefits will be available prior to July 1st, 1948.

* * * *

Manitoba Medical Service Publishes 1947 Report

According to the annual report of the Manitoba Medical Service, payments of medical accounts have been on an increased *pro rata* basis, and the balance of moneys advanced by the College of Physicians and Surgeons, the Manitoba Medical Association, and the Winnipeg Medical Society have been repaid in full. Further evidence of the fact that definite progress has been made is the return of demand notes to 130 medical members, which they had deposited at the inception of the plan, as practical evidence of faith in the venture.

* * * *

"Highlights"

A regular monthly information bulletin called *Blue Cross Highlights* has been inaugurated by the Blue Cross Plan in Ontario. The Bulletin, which has an attractive blue heading, and is both interesting and informative, will be issued to the hospitals of the province.

* * * *

Dr. A. C. McGugan Chairman of Hospital Plan

At a recent meeting of the directors of the Associated Hospitals of Alberta, Dr. A. C. McGugan, superintendent of the University Hospital, Edmonton, was appointed chairman of the board of trustees for the operation of the hospitalization plan.

Final approval was given to a bill in the legislature to incorporate the prepaid hospital plan. The bill provides for the municipal hospitals of Alberta being incorporated into the organization operating the plan.

* * * *

Blue Cross—Blue Shield Conference in Los Angeles

The Blue Cross-Blue Shield Conference was held in Los Angeles, Cal., March 29 to April 1, 1948.

Highlights of the business sessions were the acceptance by delegates from Blue Cross and Blue Shield of two proposals, i.e., to form:

1. The inter-plan benefit bank to equalize payments made by Plans in low and high cost areas to allow more Plans to participate in an inter-plan reciprocity program.

2. An effective and democratic association of Blue Cross and Blue Shield Plans to serve local Plans in the achievement of their fullest usefulness. The new association will supplement the work of the Blue Cross and Blue Shield Commissions and will provide coverage where no Blue Cross or Blue Shield is available to national employers, as well as solve the problem of uniform coverage for employees of national organizations operating in more than one state.

Ralph H. Alexander, Deputy Insurance Commissioner, Commonwealth of Pennsylvania, Harrisburg said, "Plan success started from the springboard of public confidence in hospitals. Confidence that if the Plans could not pay, the hospitals would deliver the services in any event. In other words," he said "the Plans were the children of the hospitals and now that the Plans have reached adult status they should remain members of the family".

Mr. N. D. Helland, director, Group Hospital Service, Tulsa, Okla., recommended that a program be inaugurated to educate the hospitals to their responsibility in the Blue Cross-Blue Shield movement, to include the submission of complete notices of admission and statements of accounts for Blue Cross patients as soon as the patient is admitted or discharged from the hospital; instruction for personnel in the admitting office to show a feeling of appreciation that the patient is a Blue Cross or Blue Shield member.

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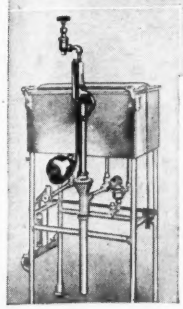

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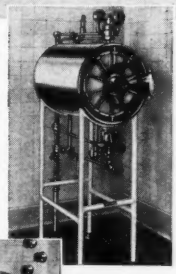

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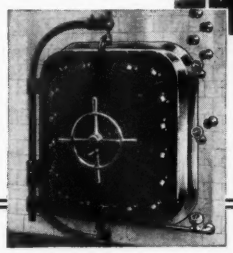

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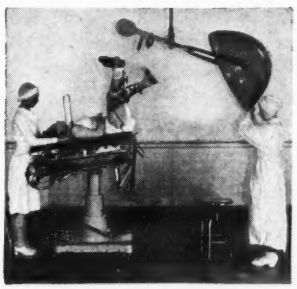

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Here and There

Bits of Medical History From Early Days in Montreal

(Excerpts from an article by Dr. Ad. Groulx, Director, Department of Health, in Bulletin d'Hygiene, Montreal.)

WHEN Montreal was discovered Jacques Cartier noted that there was much sickness among the Indians who inhabited the village of Hochelaga, the present site of McGill University. The fact that there were many blind or partly blind persons engendered the belief that this was due to Trachoma and the presence of much lung trouble—bronchitis and pneumonia, led to the conclusion that tuberculosis might also be rampant.

With the white people came also such maladies as smallpox, typhus, and cholera, which spread among the Indians.

Smallpox caused the greatest trouble and decimating epidemics reduced the Indian population in Lower Canada, Acadia and Maine, not to mention other places.

The opening of Hotel Dieu in 1639 coincides with the attempts made by the French to cope with this disease. New France suffered several epidemics traceable to smallpox.

In 1757 Montcalm reports that from 2,500 to 3,000 people were afflicted with this infection in Quebec alone. At the time of the conquest the French had 8,000 men ready to defend the city. Had today's preventive measures been employed since the inception of the colony, together with the natural increase in population, Montcalm would have had 50,000 men on the battle-field. . . .

I wish to bring to mind the terrible epidemic which raged in the Montreal district in 1885 with 19,905 cases reported and 5,864 deaths.

It was during this epidemic that the Provincial Board of Health, on September 22nd, 1885, adopted an order making vaccination obligatory upon all citizens. The enforcement of the decree caused a violent reaction from the public, even a mutiny, not to say a revolt. On the day following the promulgation of the ordinance there were demonstrations at the City Hall and in front of the offices of the newspapers.

While a quarantine committee was sitting at the City Hall the crowd gathered on Champ de Mars to protest and threw stones against the City Hall. They also made a bonfire of by-laws, newspapers and other documents dealing with vaccination. An attempt was made to attack the barracks and the Montreal regiments were called out to quell the disturbances. During that night the isolation hospital was burned down and the inmates were saved only with great difficulty. A drug store on Ontario Street which had opened up a vaccination clinic was attacked and ransacked. . . .

It required the steadfast stand taken by the Mayor of the day, Honoré Beaugrand, to bring about respect for the law. The newspapers of the time report that the Archbishop of Montreal intervened by issuing a pastoral letter enjoining observance of the vaccination law.

There was a considerable number of patients and hospitals were taxed to the limit of their capacity. Some had to be cared for in private homes. It was then decided to utilize the Exposition buildings on the grounds at the corner of Park and Mount Royal Avenues which were taken over under military law in spite of opposition from the exhibition committee. Thousands of people were cared for there under guard of militia, for several days, in order to discourage further attacks.

Remember, that to change thy mind upon occasion, and to follow him that is able to rectifie thee, is equally ingenuous, as to find out at the first what is right and just without help.—*Marcus Aurelius.*

Dr. Delaney Honoured

The many friends of Dr. W. H. Delaney, superintendent of Jeffrey Hale's Hospital in Quebec City, and long a prominent figure in military medicine, will be very pleased to note that he has been selected by his medical confrères in the Province of Quebec for election to senior membership in the Canadian Medical Association. This honour will be conferred at the forthcoming convention in Toronto, June 21-25.

With characteristic humour and modesty "Colonel Bill" has penned this observation to the Editor:

"It is awfully sad to note the deterioration of the quality of the Canadian Medical Association when they have to pick a fellow like me as Senior Member. When one thinks of the wonderful men so honoured in the past with senior memberships, one wonders what will happen in the next twenty or twenty-five years if the deterioration goes on at the same pace as in the past.

"Sic transit gloria mundi."

The Error

The typographical error is a slippery thing and sly.
You can hunt till you are dizzy, but somehow, 'twill get by.
Till the forms are off the presses, it is strange how still it keeps;
It shrinks down in a corner and it never stirs or peeps,
The typographical error, too small for human eyes,
Till the ink is on the paper, when it swells to mountain size.
The boss he stares with horror, then he grabs his hair and groans;
The copy reader drops his head upon his hands and moans—
The remainder of the issue may be clean as clean can be,
But that typographical error is the only thing you see!

—Anon., from "The Writer's Studio".

Book Reviews

DIABETES AND THE DIABETIC IN THE COMMUNITY. By Mary E. Tangney, R.N., Diabetic Supervisor, Hartford Hospital, Connecticut. Pp. 259. Price $3.00. 1947. Canadian agents, McAinsh, Limited, Toronto.

As the role of the nurse in public health services becomes more and more important, this practical textbook on diabetes, with its emphasis on the instruction of patients, in their homes, in the schoolroom and in industry, answers an essential need. The book has been written from the viewpoint of teaching the diabetic person in the community rather than the nursing of diabetic patients in the hospital.

Serving as she has done, at the George F. Baker Clinic and at the Hartford Hospital as Diabetic Supervisor, Miss Tangney writes from long experience in dealing with diabetics and shows deep understanding of their emotional and psychological problems. All aspects of the complications of re-adjustment to normal life have been covered, with special chapters on the education of mothers who have diabetic children, showing how to handle them with tact, knowledge and understanding. The valuable information contained in this book will be a great help to both the graduate and student nurse.

* * * *

INTRODUCTION TO MEDICAL SCIENCE. Second Edition. By Gulli Lindh Muller, M.D., Pathologist and Director of Clinical Laboratory of the New England Hospital for Women and Children, Boston, and Dorothy E. Dawes, R.N., M.A., Science Instructor, Teaching Service for Schools of Nursing, Boston. Illustrated. Pp. 580. Price $4.50. Canadian agents, McAinsh & Co. Limited. 1948.

In the second edition of this valuable handbook for the student nurse, alterations in the text have been made to show recent findings in the field of medical science, and in many cases whole chapters have been rewritten in order to include such important subjects as the revolutionary advances in surgery of the heart; the antibiotics, such as penicillin and streptomycin; the therapeutic value of amino acids and the use of the electroencephalogram in diagnosis of diseases of the brain.

Recent legislation in the public health field has necessitated reorganization of the chapters on community health programs, special attention being given to the current developments in the treatment of rheumatism, tuberculosis and cancer. Newer illustrations have also been added.

For the assistance of the instructor a teaching guide has been prepared and definite aims are given for each chapter, followed by leading questions for the lecture outline. The text is followed by a glossary, which should prove useful to the student.

In presenting this second edition, the authors follow closely the lines of the original book, designed for the student nurse prior to service on the wards.

* * * *

INTRODUCTION TO PSYCHIATRY. Second Edition. By W. Earle Biddle, M.D., Assistant superintendent, Wernersville State Hospital, Wernersville, Pennsylvania, and Mildred van Sickel, B.S., R.N., Educational Director, Norristown State Hospital, Norristown, Pennsylvania. Pp. 344. Illustrated. Price $3.25. 1948. Canadian agents, McAinsh & Co., Limited.

More and more people are hospitalized each year for psychiatric treatment. The result is that more types of personnel have been brought into the field, in addition to those directly concerned with treatment, for the training and care of mental patients. Included among these are psychologists, affiliate nurses, social workers, occupational therapists, et cetera, and it is to this group that this book will make special appeal. The authors have pointed out the constant and important contact these workers have with the patients, affording many opportunities to affect their welfare. The need for special training of all who assist in the care of the mentally ill is stressed.

In this second edition many of the chapters dealing with individual psychoses and their special care have been rewritten and much attention has been given to occupational and recreational therapy, and the broader aspects of treatment and prevention of mental disorders. The mental hygiene section has been expanded in view of the increasing importance of the public health nurse, the industrial nurse and social worker.

From their long experience in dealing with the mentally-ill patient, the authors have presented an understandable and easily read work of great interest to the layman and all who are responsible for the care and treatment of the mental patient.

* * *

COMMUNICABLE DISEASES FOR NURSES. By Albert G. Bower, A.B., M.S., M.D., F.A.C.P., Professor of Communicable Diseases, the College of Medical Evangelists, Los Angeles; Clinical Professor of Medicine, University of Southern California, Los Angeles; and Edith B. Pilant, R.N., Director of Nursing, Los Angeles County Hospital, Los Angeles. Sixth edition. Pp. 657, Illustrated. Price $4.50. Published by W. B. Saunders Company. Canadian agents, McAinsh & Co., Limited, Toronto.

The new edition of this standard text for nurses has been extensively revised to include the latest developments in care and treatment of communicable diseases. The chapter on chemotherapy has been expanded to cover the antibiotics and the newest information concerning the sulfonamides. Disease entities introduced in this edition include relapsing fever, exanthem subitum, primary atypical pneumonia, and epidemic keratoconjunctivitis. There is also a section on the various nonsyphilitic venereal lesions. The chapter on poliomyelitis has been entirely revised and contains instruction concerning the most modern technics in the care of this disease.

Besides the chapters dealing specifically with each of the commonly-known communicable diseases, the authors again provide a thorough discourse on medical aseptic technic and another on the care of communicable disease in the home.

Each section is well illustrated with photographs, charts and numerous colour plates. The last fifty pages of the volume contain a detailed glossary of medical terms and a lengthy index, both of which add greatly to its value. The type chosen and general format of this book is

(Concluded on page 94)

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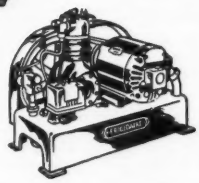


Provincial Notes

British Columbia

LILLOOET. As the result of the Canadian Red Cross Society drive, an outpost hospital was opened at Lillooet last month by Dr. George Lamont, chairman of the society's Outpost Hospital Committee.

The new institution, which will serve an area from Lytton to Bralorne and Ashcroft to Pemberton, is operated by Red Cross personnel at no cost to the community.

* * * *

VANCOUVER. The retirement is announced of Miss E. M. Kathleen Panton, who has been on the staff of Shaughnessy Hospital for the past thirteen years, six and a half of which were spent as matron of the institution.

Miss Panton graduated from the Toronto Hospital for Sick Children, and later went overseas as a nursing sister in World War I, when she was awarded the Royal Red Cross. On returning to Canada she took a post-graduate course in hospital administration and teaching of nursing at McGill University.

A successor to Miss Panton has not yet been announced.

* * * *

VANCOUVER. The new 50-bed wing of the Children's Hospital was opened recently, bringing the hospital's bed capacity up to 100. This unit is of ultra-modern design and contains a spastic unit to which children are brought daily from their homes in autos for special treatment.

Alberta

EDMONTON. Construction of the new Aberhart Memorial Sanatorium on the university campus in Edmonton is to begin this spring. The building, which will have space for 250 to 300 beds, will be a four-storey steel and concrete structure and will be fireproof throughout. There will be sitting rooms and solaria on each floor, and a sun deck on the roof. The entire cost, estimated at $1,500,000, is being covered by the province, according to a recent statement by the Hon. W. W. Cross, Minister of Health and Public Welfare.

* * * *

SMOKY LAKE. A $20,000 addition to the Smoky Lake Hospital was officially opened there a short time ago. The new structure will house an operating room, a maternity department, an x-ray room and a modern heating unit. To further modernize the institution there will be new laundry facilities. The hospital is operated by the Home Mission Board of the United Church of Canada.

Saskatchewan

SASKATOON. A large crowd, representing different social agencies, was present when a new wing was recently opened at the Salvation Army Bethany Hospital in Saskatoon.

The new building, which contains two wards, delivery room, nursery and clinic rooms, will provide accommodation for 24 women. The cost was $37,000, $10,000 of which was provided by the provincial government.

Manitoba

CARMAN. Decision has been reached by the board of directors to proceed with the construction of a 44-bed hospital at Carman, for Carman Memorial Hospital district No. 20. It is estimated that the building, which will be modern in all respects, will cost $165,000.

* * * *

WINNIPEG. A fund for a scholarship for nurses is being established by the medical staff of the Children's Hospital as a tribute to the memory of the late Dr. Gerald Williams, who was superintendent of the hospital for many years. The scholarship, which is to be awarded annually, has been tentatively set at $250.00 and is designed to assist the nurses chosen to carry out short term post-graduate study.

Ontario

BARRIE. The Rotary Club of Barrie has launched a campaign with the high objective of raising a million dollars for a memorial hospital to replace the overcrowded Royal Victoria Hospital, which was built in 1902. More than a quarter of a million dollars is already in sight, with the drive still in its earliest stage.

The new hospital, by present plans, will have 150 beds, and permission has been received for part of the new building to be named the Barbara Ann Scott unit.

* * * *

FORT WILLIAM. A central heating plant to serve McKellar Hospital and adjacent buildings will be constructed this year. The new plant which will cost $200,000, will serve the nurses' homes, Quonset hut, and a contemplated new hospital wing.

* * * *

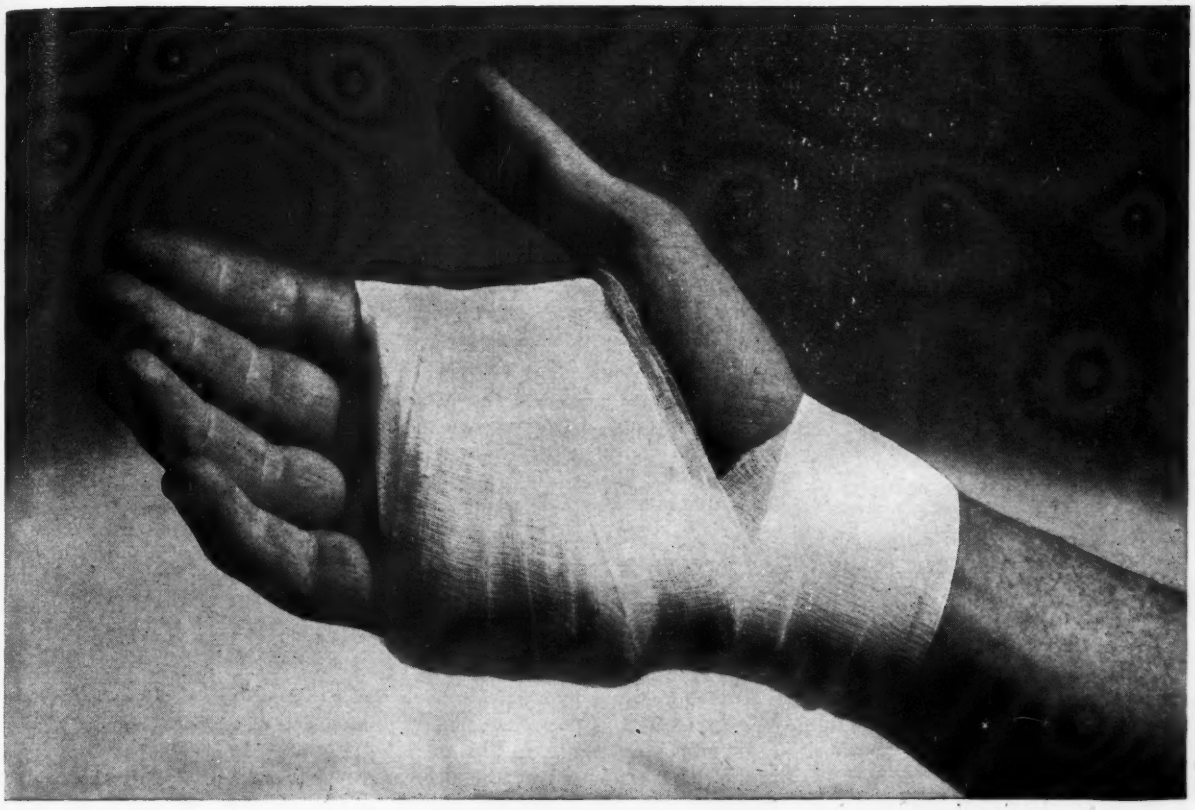
NORTH BAY. A new five-storey Civic Hospital is to be built in North Bay in the near future. The building will have an 80-bed capacity and construction will begin as soon as materials are available.

* * * *

KINGSTON. As part of the expansion program of the Hotel Dieu Hospital, the old Regiopolis building, the cornerstone of which was laid in 1839, has been torn down. In its place will be built the new $400,000 Centenary Wing which will house the paediatrics and obstetrics departments.

Destruction of the old building was carried out expeditiously, and it is expected that the new wing will be built during this summer.

(Concluded on page 92)



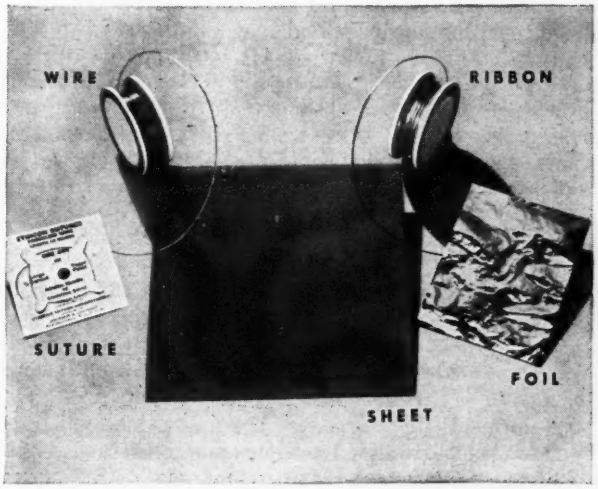
TANTALUM in Traumatic Surgery

A SURGEON'S REPORT "I have used tantalum wire suture material on all our hand injury cases for the past year and have a large series of them to look back upon.

"I have used the tantalum wire for both buried and cutaneous suturing. In this fairly large series of cases I have not yet seen any evidence of anything but minimal tissue reaction.

"I have not yet had a single infection in any of the cases where tantalum wire was used in these hand cases, which, to me, is quite remarkable because I am sure you will appreciate how difficult it is to obtain bacterial and physical cleanliness in working with the hand of the factory worker.*"

*Olson, C.T.: "The Place of Tantalum in Surgery," Industrial Medicine, 13:917, November, 1944.



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Australian Health Benefits to Include Free Medicines

THERE will come into operation shortly throughout Australia a scheme to provide all persons ordinarily resident there, without cost to themselves, with such pharmaceutical benefits as are necessary for their treatment.

The scheme, part of the Federal Government's health and social services program, is authorized by a Federal Act, passed in 1947, which provides for the compilation of a formulary clearly defining the scope of the benefits to be available. The work of compilation is placed in the hands of a permanent committee, comprising a chairman and six members. Three of the committee are medical practitioners, and it includes pharmacologists and pharmacists. The committee will review the formulary at regular intervals to keep the range of medicines abreast of medical science and experience.

A prescription, which must be in authorized form and signed by a medical practitioner, will be presentable to any chemist or dispensary approved under the Act. Apart from such extras as special postage or delivery costs, or a small charge for prescriptions supplied outside usual trading hours, which must be paid by the patient, the prescription will be supplied free of charge. However, all prescriptions, to receive the benefit of the Act, must consist of items included in the formulary. Since this contains a full list of drugs and medicines in common use, it is hoped that the public will receive a service not only as good as present practice, but actually better, because of the elimination of drugs long since superseded.

The formulary compiled by the committee and known as the *Commonwealth Pharmaceutical Formulary*, includes all the newer drugs, such as penicillin and the sulphonamides, as well as a full range of formulae used in modern medical practice. No medicine has been or will be excluded on the ground of cost, and all new therapeutic agents which have satisfied clinical investigation have been added, while others will be added as they appear. The formulary also includes a restricted range of surgical dressings and medical appliances.

The medical practitioner will write on the authorized form the name of the drug, formula, surgical dressing or medical appliance, included in the formulary, which he is prescribing, and his directions for use. This will be supplied by any approved chemist or dispensary. Where the practitioner prescribes a continuation of the treatment over a period, he may authorize the chemist to repeat the prescription a specified number of times. All approved chemists and dispensaries will display a coloured sign containing the Australian coat-of-arms and the words "Approved Pharmaceutical Chemist".

At the end of each month, each approved chemist or dispensary will forward to the Federal Department of Health for payment, all prescriptions dispensed. A special committee in each State will deal with complaints or disputes and make recommendations on each to the Director-General of Health.

Where no pharmaceutical services are available, local medical practitioners will supply benefits. Benefits will be available to all patients receiving treatment in or at hospitals.

Steps Toward the Prevention of Colds

For many years experiments have been conducted in the prevention of colds and it now appears that there is sufficient evidence for the belief that they can be prevented. While previous experiments with germicides, chiefly hexylresorcinol, in spray form, had met with some success, further research has revealed that the glycols—propylene glycol and tri-ethylene glycol—which have a remarkable affinity for water, are far more effective. It has also been proved that it was not the spray droplets which killed bacteria, but the minute amount of glycol *vapour* formed when the glycols are broken into a spray. The great affinity which these molecules have for water makes them penetrate the moist bacteria and establish a heavy glycol concentration inside the bacterial cell. The results achieved with a glycol vaporizer are ten times better than those obtained with a spray. A single drop of tri-ethylene glycol, vaporized, will disinfect a small room almost instantly.

One of the first jobs of the Commission on Air-Borne Infections, set up during the war by the United States Surgeon General, and headed by Dr. O. H. Robertson of the University of Chicago, was to find out if this vapour, which they had found to be so effective in killing bacteria, was injurious. Many doctors took part in the first experiments which revealed no harmful effects on animals. By 1943 they were prepared for mass tests on humans. Here again, no ill effects were found while the incidence of colds was considerably reduced. In three full winters of testing at the Children's Seashore House in Atlantic City, N.J., glycol-vapour-protected children had only 13 infections; unprotected children in other wards had ten times as many.

Scientists were at first puzzled by the reduction of infections among people who spend only a part of their time in a glycolized atmosphere. However, it has been found that propylene glycol has pronounced antibiotic effects in the serum of the blood and people who inhale glycol vapours for a few hours daily at work may well be developing sufficient antibiotic protection to fight off the minor infections with which they come in contact.

Buildings with air-conditioning or air - circulating systems can be equipped for glycol vaporization at a very low cost, and may be operated for a few cents a day.

Should final results of the experiments bear out the hopes of investigators, science may have a means of preventing almost all the cross-infections in contagious disease hospitals. The greatest immediate possibility for glycol vapours, however, lies in the zone of cold prevention.

—Condensed from an article in "Hygeia"

Two favorite Soups now conveniently packed for Hospital Use

Among the many famous 57 Varieties now available in large containers for use in hospitals and institutions are two flavorsome, nourishing soups—Cream of Tomato, and Chicken Noodle. The new, 48-oz. tin offers both convenience and economy for quantity-serving. Because these soups are *Condensed*, you get double the quantity—at least 16 ample servings—by merely adding an equal amount of milk or water.

Your Heinz representative will gladly tell you about other 57 favorites packed in large economical size tins such as Tomato Juice, 2 kinds of Baked Beans, Cooked Spaghetti, and Sweet Pickles. In addition, he can supply you with many Heinz varieties in regular packages for staff tables and special dietary use. Be sure to get full details the next time your Heinz man calls.

FREE LITERATURE. The following charts and booklets, of special interest to Doctors, Nurses and Dietitians, are now available: *Nutritional Chart; A Guide To Better Nutrition; Food Caloric Content Chart; The Nutritive Value of Vegetables; The Story of Food Preservations;* a 96-page illustrated brochure. Write H. J. Heinz Company of Canada Ltd., 420 Dupont St., Toronto.

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STATICIN* Caronamide, a new drug developed by the Medical Research Division of Sharp & Dohme, now makes possible therapeutic blood concentrations of penicillin with ¼ the usual dose of the antibiotic. In conditions where oral penicillin, 100,000 units every three hours, is effective, 25,000 units plus STATICIN Caronamide exerts equal therapeutic action. Clinical trials have revealed relatively no toxic effects.

STATICIN Caronamide saves 75-80% of circulating penicillin by means of unique, reversible inhibition of the tubular excretion of penicillin. In effect, STATICIN Caronamide competes successfully with penicillin for combination with an enzyme responsible for tubular excretion of the antibiotic, and thus temporarily inhibits excretion of the latter.

Supplied in 0.5-Gm. tablets. When given by mouth with orally or parenterally administered penicillin, STATICIN Caronamide characteristically increases blood levels of the antibiotic an average of 400%, thereby permitting 75% reduction in the usual doses of penicillin. When STATICIN Caronamide is administered, the customary penicillin dosage will produce *four to eight times the usual blood concentrations of the antibiotic*, a fact that may prove exceptionally useful in treatment of osteomyelitis, subacute bacterial endocarditis, typhoid fever, and other highly resistant infections.

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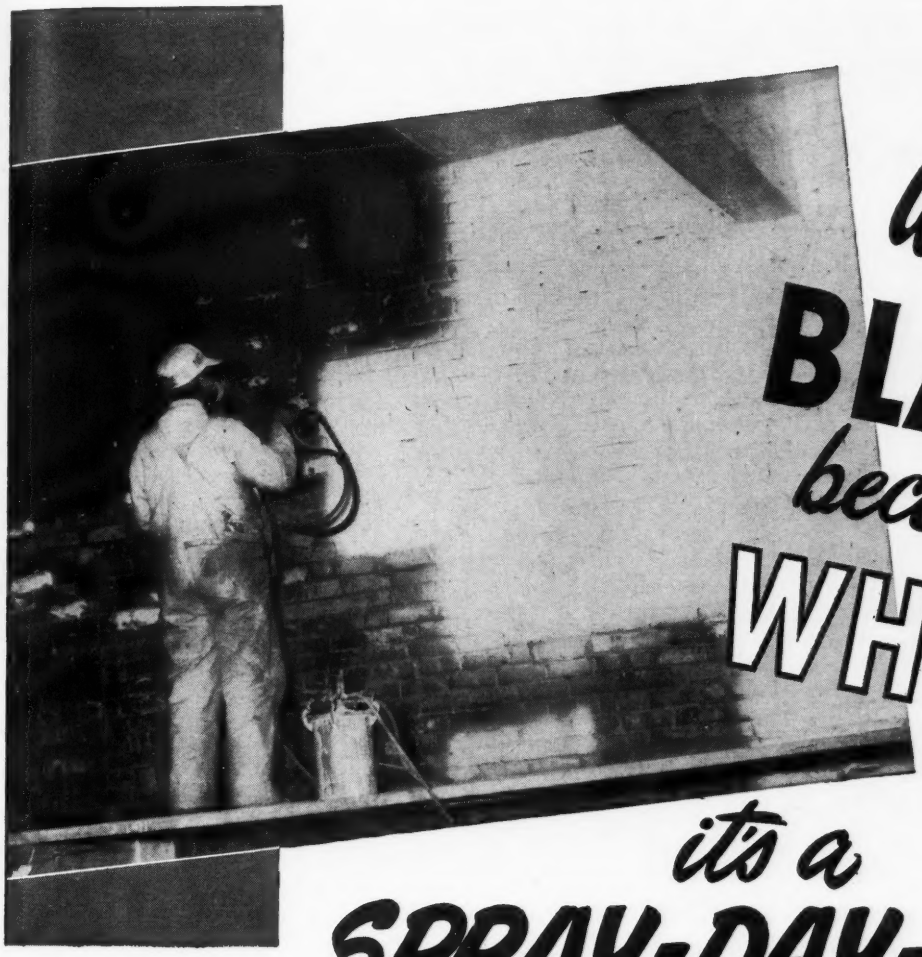

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Negotiations Pending

The B.M.A. and Mr. Bevan

IN our March issue (pages 34 and 46) an outline was given of the results of the plebiscite which reflected the attitude of the medical profession in Great Britain toward the National Health Services Act, slated to go into operation on July 5th.

Special representatives of the British Medical Association, at a meeting on March 17th, adopted a resolution incorporating a recommendation placed before them by the Council of the B.M.A. This resolution urged that changes should be made in the above Act and expressed the hope that through such changes the Government would make it possible for the profession to co-operate. It was made clear that if the Government refused to change an Act which was unacceptable to 80 per cent of the profession, then doctors would exercise their right to remain outside the service. The Representative Body was in a decisive mood and inclined to think the Council's recommendation was not worded in strong enough terms.* It would have been all too easy at this point to make a difficult situation impossible, especially when medical authorities were being provoked by unpleasant propaganda on the part of trade unions and local labour party organizations.

At the above meeting, Lord Horder stated firmly: "We must not yield on any of the points which, collectively and individually, spell the doctor's freedom." However, the door was held open for negotiation, and the attitude of the profession was expressed in the concluding remarks by Dr. H. Guy Dain, Chairman of the Council:

"Our position today is that we are willing to explore the problems afresh, provided that the outcome is a service in which the medical profession remains an independent profession, secure from domination by the State. We doctors want a health service. We want our services to be available to all who need them. We are ready to enter into any discussions directed to making it possible for the medical profession to co-operate with the Government. If the Government can show us other ways, new ways, of preserving our independence we are willing to listen. But if this cannot be done we owe it to the public to make our stand."

It will be remembered that after the B.M.A. plebiscite and prior to this meeting, Mr. Bevan's attitude had been distinctly belligerent. At that time he made it plain that he expected "concessions, not arguments" from medical men. However, it would appear from notes in the public press that, since the B.M.A. also took a firm stand, Mr. Bevan has done some fast thinking. On April 7th, it is reported, the Minister of Health informed the House of Commons "in a conciliatory tone," that the Cabinet proposed to offer an amending bill in parliament which would make it impossible for the Government to institute a full-time, state-salaried medical service without express legislation. Also, according to the proposed amendment, doctors, except for their first three years in practice, would not need to accept the basic annual salary of $1,200 offered to those operating the national health service. He concluded by saying that he hoped he had freed physicians of the fear that they would become civil servants and that he would "always" be willing to meet their representatives. The executive committee of the Council of the B.M.A. promptly called a special meeting to discuss re-opening of negotiations with the Government.

B.M.A.J. editorial, March 27, pg. 604.

Mrs. Jean U. Fielding

Mrs. Jean Urquhart Fielding of Windsor, Nova Scotia, passed away on March 14th after a lengthy illness. Mrs. Fielding was one of Canada's pioneer newspaper women, having been editor and joint owner of the Windsor Tribune since 1905.

Mrs. Fielding was one of the founders of the Hospital Association of Nova Scotia and Prince Edward Island when it was launched in 1928. Those who attended the earlier conventions of that Association will long remember the blunt, straight-forward, contributions of this little lady who was always impatient with delay and procrastination, and who said exactly what she wanted to say, let the chips fall where they may.

Mrs. Fielding was keen for the organization of a larger Maritime Association—an organization which has since more than justified the hopes of those who were so interested in it. She was spokesman on the National Red Cross Council for the proposed outpost hospital in North Cape Breton and succeeded in having this hospital established.

Mrs. Fielding, although small in stature, made her newspaper known from coast to coast by her militant attacks on whatever needed to be corrected and by the stinging brilliance of her editorials. Essentially a crusader, whether it be for the W.C.T.U. or for the local hospital, her greatest pleasure was in finishing one task and then starting another. Mrs. Fielding organized the first Red Cross auxiliary in Nova Scotia at the beginning of World War I and was a Councillor of the National Society. She was honoured with the Canadian Red Cross honorary medal in 1936 and has received many other decorations. She was a member of the Board of the Payzant Memorial Hospital at Windsor for many years.

Mrs. Fielding's husband, Peter Fielding, a Windsor business man, died several years ago.

New Diabetes Laboratory Planned by University of Toronto

To further the study of diabetes, a new, modern research laboratory is being planned at the University of Toronto. The unit, which will be under the direction of Dr. H. Best and his associates, will be financed by funds subscribed by diabetics both in the United States and Canada, according to a recent announcement. President Sidney E. Smith has stressed the need for more space and increased facilities.

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New Light on the Malaria Parasite

Ian Cox,
British Broadcasting Corporation.

ALMOST important addition to our knowledge of malaria has been announced by Professor H. E. Shortt and Dr. P. C. C. Garnham of the London School of Hygiene and Tropical Medicine.

Investigating the microscopic parasite that causes monkey malaria (plasmodium cynomolgi) they have found developmental stages in the liver of the infected animal, thus establishing the so-called "tissue form" in the life history of this parasite which, although it has been postulated, has never been isolated or seen. Plasmodium vivax, which causes human tertian malaria, is very closely akin to the monkey malaria parasite, so there is a very strong possibility that it, too, will prove to follow the newly discovered developmental cycle.

The significance of Shortt and Garnham's announcement is that it fills in the last gap in our understanding of the complicated life history of parasites that cause mammalian malaria. They are minute unicellular organisms, capable of reproducing themselves with great rapidity and in different forms, at different stages in the life cycle. From the point of view of human discomfort, the most important part of this cycle is spent in the red blood corpuscles of the host. Here each individual (called at this stage a schizont) reproduces itself by successive divisions until the corpuscle breaks up, setting free the new generation (merozoites) and with them the toxins produced in the course of their metabolism. It is these toxins, liberated into the bloodstream of the host, that result in the fever—the difference between "tertian" (three-day), "quartan" (four-day) and "pernicious" malarias being the difference in the time the three species of plasmodium take to produce and set free a generation of merozoites.

A mosquito of the genus *Anopheles,* sucking the blood of an infected person, will take into its stomach certain descendants of these merozoites which have male and female potentialities. These conjugate by pairs in the gut of the insect and become transformed into an elongated form which burrows through the gut wall and encysts on the outer surface of the stomach. Eventually it multiplies by division within the cyst, producing spindle-shaped sporozoites which are carried in the mosquito's blood stream to its salivary glands. From here the sporozoites are injected into a mammalian host when the insect sucks blood.

Many years ago, an observer claimed to have witnessed sporozoites actually penetrating the red cells of a new host after which they were said to develop into merozoites as I have described; later work, however, showed that the complete life cycle was not as simple as this. It was found. for example, that subjects inoculated with blood containing malaria parasites could be cured permanently after infection by quinine, and that if quinine were taken while the parasites were incubating in the blood cells, the infection could be prevented altogether. If, on the other hand, the subjects were inoculated with malarial sporozoites from a mosquito's saliva, then quinine given during the incubation period failed to prevent an attack of malaria. It was clear, then, that infection produced by sporozoites differed fundamentally from that resulting from injections of blood in which parasites were already lodged in the corpuscles, and it became accepted that sporozoites, on entering the host, do not go straight to the corpuscles but pass first into the tissues and then undergo further development before they re-appear as the familiar trephozoites. The problem as far as human, or near-human, malaria parasites were concerned, however, was: What tissues? This question remained unanswered until early this year when Shortt and Garnham announced that they had located the tissue stages of plasmodium cynomolgi in the liver of a monkey which had been strongly infected with sporozoites seven days previously. These schizonts show up in stained thin sections of the liver as roughly ovoid bodies with a diameter of up to one-thirtieth of a millimetre. The majority of them are then nearly mature and at the stage immediately preceding the multiple division to give merozoites.

Why these "tissue stages" have so far eluded investigators who have been looking for them keenly during the last few years is due probably to a variety of reasons. In the first place, very heavy dosages of sporozoites are necessary if developmental forms are to be found easily; secondly, practice hitherto has favoured the examination of smears rather more than of thin sections, and parasites are far less readily found by the former means. It is possible, too, that the tissue forms may be evanescent, the majority disappearing when the cycle within the blood corpuscle has been established. Another factor that may have led to the schizonts escaping recognition is their relatively large size. Already, following on Professor Shortt's demonstration, reports are being published confirming his discovery by the finding of similar parasites in other laboratories.

Application of the discovery to the problems of human malaria may be expected to follow rapidly. The *Lancet,* for example, suggests that plasmodium falciparum (which is the cause of pernicious malaria) develops in the human liver for five to six days in the same general form as plasmodium cynomolgi in a monkey, and that the tissue form then probably dies out soon after infection has developed in the blood corpuscles. Plasmodium vivax (which is responsible for tertian malaria), it is suggested, develops in the liver for six days and the schizonts probably persist there for from one to three years, giving rise at intervals to the relapses typical of tertian malaria. The tissue forms of quartan parasite (plasmodium malaria) probably persist for 20 years. Verifications of such suggestions should, in the light of Shortt and Garnham's work, prove simple.

Courtesy of the United Kingdom Information Office, Ottawa.

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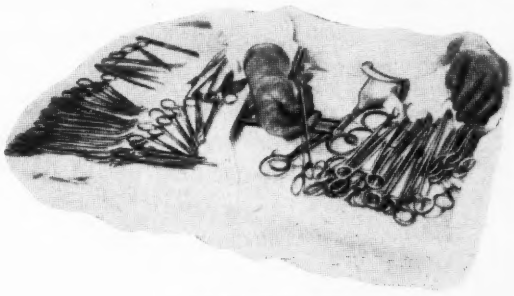

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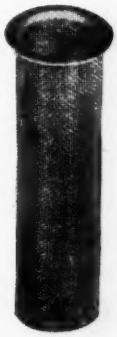

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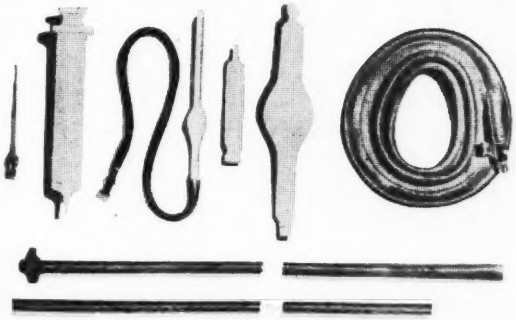

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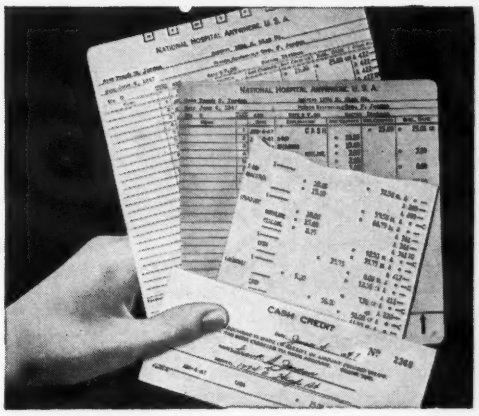

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Problèmes Légaux

(Concluded from page 34)

Discrétion professionnelle

Au point de vue légal, la plus stricte discrétion professionnelle doit régner dans un hôpital. Le moindre écart à cette règle peut entraîner des réclamations légales contre la personne mise en cause, et contre l'institution. Pour ne mentionner que les cas généraux, disons que le médecin n'a pas le droit d'informer les membres de la famille d'un patient de l'existence de maladie vénérienne; il a toutefois le devoir de rapporter un tel cas au service de la Santé, qui verra à prendre les mesures qui s'imposent, et aussi à l'Hôpital, pour le bénéfice du patient.

Responsabilité légale de l'hôpital

L'administrateur d'un hôpital ne doit pas oublier que, même dans les cas de réclamations où l'institution n'est pas directement intéressée, mais plutôt le médecin ou l'infirmière privée, il sera appelé à donner des explications pour ne pas dire davantage.

De façon générale, l'Hôpital est tenu responsable des erreurs de son personnel hospitalier, et particulièrement de celles de ses hospitalières. La loi, toutefois, fait exception pour les erreurs non professionnelles commises par les infirmières: il limite la responsabilité de l'employeur aux actes administratifs seulement. En vertu de cette clause de la loi, l'Hôpital est tenu de fournir l'équipement nécessaire et un personnel compétent.

L'Hôpital ne saurait être tenu responsable de la négligence d'un médecin ou des erreurs d'une infirmière privée.

En vue de protéger son institution contre toute réclamation éventuelle, l'administrateur devra surveiller l'équipement mis à la disposition de son personnel, même s'il est couvert sur tous points par des compagnies d'assurances. Il devra tout particulièrement s'assurer de la compétence de son personnel médical; dans le doute, il devra soumettre le ou les cas particuliers au Conseil médical pour enquête.

Paiement des comptes d'hospitalisation

Dans les cas ordinaires, le patient est requis de signer une garantie de paiement lors de son admission. Il est fait exception des cas suivants:

1) patients admis à la suite d'un accident, et pas en mesure de fournir les informations nécessaires;

2) patients hospitalisés en vertu de la loi de l'Assistance publique;

3) accidentés du travail, dont l'hospitalisation et les traitements sont payés par la Commission des Accidents du Travail;

4) patients porteurs d'un contrat de la Croix Bleue, si ces derniers sont satisfaits de l'accommodation prévue par leur police.

Articles de valeur

Les hôpitaux mettent à la disposition des patients une voûte et des boîtes de sûreté. Les patients sont requis de déposer les articles de valeur au service de comptabilité, jusqu'à leur départ: si cette précaution n'est pas prise, l'Hôpital n'en sera pas responsable.

Des avis à cet effet devront être placés dans les chambres, ou apparaître aux formules que le patient sera appelé à signer.

Testaments

Il y a trois genres de testaments:

a) olographe

Ce testament est entièrement écrit de la main du testateur et signé par ce dernier. Il est valide dans la province de Québec et ailleurs au Canada. Il est nécessaire, toutefois, de le faire accepter par la Cour et d'établir son autenticité, qui est d'ailleurs chose facile s'il est accompagné d'un affidavit à cet effet, entièrement écrit par le testateur.

b) testament, formule anglaise

Ce testament est généralement écrit soit au crayon, à l'encre ou au dactylo. Il doit être daté, signé par le testateur en présence de deux témoins qui doivent également signer. Ce testament est valide dans toutes les provinces du Canada. Il doit être accepté par la Cour et prouvé par affidavit d'une des personnes agissant comme témoin.

Les témoins dont la signature apparaît ne doivent pas être apparentés au testateur, bénéficiaires en vertu du testament ou exécuteurs testamentaires. Ces témoins doivent nécessairement être âgés d'au moins 21 ans.

c) testament public ou authentique

Ce testament est rédigé par un notaire public. L'original demeure à l'étude du notaire. Une ou des copies sont émises par le notaire, sur demande, au décès du testateur. Ce testament est valide sans autorisation de la Cour.

Pour conclure cet exposé, l'Hôpital doit, en tout temps, s'assurer les services d'un avocat compétent, à qui le Bureau d'administration doit soumettre tous les cas, mêmes d'importance mineure.

Spontaneous Combustion in Wiping Towels

Laundries are sometimes called upon to wash fabrics which carry a potential fire hazard. Some time ago a laundry submitted a number of wiping towels which had taken fire while standing in a truck after having been laundered and tumbler dried. Examination of the towels indicated that they contained approximately one per cent of oily material which had not been removed in laundering. The towels possessed the characteristic odour of linseed oil and had probably come in contact with this material during use.

Raw linseed oil as used in many paints, et cetera, readily undergoes oxidation through contact with the oxygen of the air. Heat is evolved in this oxidation process and if the oil being oxidized is distributed over a textile fabric and the latter is in a confined space (as in a load of towels in a truck) this heat may be sufficient to raise the temperature of the mass of fabrics to the combustion point—in other words, "spontaneous combustion" occurs.

We would warn any members who process towels, wiping rags, et cetera, which may have come into contact with oily materials during use to treat such work with great care, since it certainly constitutes a potential fire hazard before laundering, and as will be seen from the above case may still be a fire hazard even *after* laundering. It cannot be assumed that the laundry process will in all cases completely remove the dangerous oils present.

—Canadian Research Institute of Launderers and Cleaners.

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PRE-ADMISSION X-RAY *Problem*

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- **Space requirements are held to the bare minimum, permitting the unit to be placed in a location convenient to the admitting desk.**

To sum up, the Ferranti PHOTOSCOPE is the only X-Ray unit designed specifically for hospital pre-admission X-Ray examination, providing economy of first cost, economy of operating cost and economy of space. Write today for further details of this important new Ferranti development.

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Clinical Experience has indicated that, as an adjunct to conventional therapy, Streptomycin is the most effective chemotherapeutic agent in the treatment of certain cases of tuberculosis. In selected cases, Streptomycin has been found effective in shortening the period of disability. The new, improved form of this valuable antibacterial agent — Streptomycin Calcium Chloride Complex Merck — provides three noteworthy advantages:

1 *increased purity*

2 *minimum pain following injection*

3 *uniform potency*

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Sodium Citrate 3% Solution . . . Dextrose-Citrate-Buffer Solution (closed technique) . . . **A-C-D Solution** (closed technique). All in sterile containers, ready for use . . . Also empty sterile containers for plasma pooling and storage.

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Intravenous Solutions *and* Venoclysis Equipment

Legal Problems

(Concluded from page 33)

The ordinary act shows the employer to be responsible for the acts of his employee. Generally speaking hospitals are responsible for the acts of its nurses. Certain limitations have been placed on this doctrine in its application to hospitals. The hospital is not liable for the act of the nurse unless it is not a professional act but an administrative act. Under this clause, the hospital is bound to provide proper equipment and properly trained staff to use the equipment.

The hospital is not liable for negligence of a doctor, or for injury caused by neglect on the part of a special nurse.

While it is true that hospitals usually carry insurance and the insurance company acts on behalf of the hospital to determine the facts according to the interpretation of the law, the hospital administrator should not relax on this account in continually observing the procedures of his hospital regarding the legal aspects. He should keep a watchful eye on the deterioration of equipment, buildings, and the qualifications of his personnel in handling technical responsibilities. The appointment of qualified physicians, and surgeons, should be carefully scrutinized. This is usually done by special committees of the medical board of the hospital.

Guarantee of Payment

Upon admission to hospital the patient is requested to sign a *guarantee for payment* of the accommodation he or she is admitted to, except the following:

1. If an accident, then sometimes the status of the patient is not obtainable, and said status is determined later.

2. An indigent patient whose hospitalization is covered by an Act of the Province. In the Province of Quebec this Act is known as "The Quebec Public Charities Act".

3. A Compensation case whose hospitalization is covered by Workmen's Compensation Act.

4. A patient who has hospital coverage by Blue Cross. In Quebec this is carried by the Quebec Hospital Service Association, unless the coverage provides only part of the hospitalization as in the case of a private patient.

The effect of a guarantee for payment can be used long after the patient has been discharged, in the event of default of payment of account. It is binding in Courts of Law.

Valuables

The hospital should provide a safe place for safekeeping of patients' effects left in their charge, e.g., rings, purses, jewelry, money, papers, et cetera, and maintain a good system of acknowledging receipt and return thereof to the patient. There should be a notation on guarantee of payment form to the effect that the hospital is not responsible for valuables kept at the bedside.

Wills

There are three types of wills, viz;

(a) *Holograph Will*

A will that is entirely written in the handwriting of a testator, signed by him or her and dated, is known as a holograph will, and is valid in the Province of Quebec and elsewhere in Canada.

This will requires to be probated and its authenticity is proven by affidavit that it is entirely written in the handwriting of the deceased, and that the signature thereto attached is his or her proper signature.

(b) *Wills in English Form*

This will may be written in pen or pencil and may be typed or printed. It must be dated and signed by the testator, however, in the presence of two witnesses who are present when the testator signs and who sign in the presence of each other. This will is good in every Province of Canada. It requires to be probated by affidavit of one of the subscribing witnesses.

(c) *Notarial Wills*

These wills are prepared by notaries. The original remains in the possession of the notary, who is bound to issue an authentic copy upon death of the maker of the will. Probate is not required.

Regarding wills in English form —the witnesses of these wills should not be related to the testator. No beneficiary, under such a will, should be a witness thereto, and no executor thereof should be a witness. Witnesses should be twenty-one years of age or over.

In conclusion, as we say that first aid ends where the doctor begins, so do the legal aspects of the hospital and its administrator end wherever the lawyer begins.

The hospital should retain the services of a lawyer on its board of management and there should be no hesitation in referring even minor legal details to him.

King George V Silver Jubilee Cancer Fund Aids Institute

The trustees of this Fund met recently in Ottawa and authorized a second payment of $150,000 from their original grant to the National Cancer Institute to assist in the fight against this disease.

During the past year the Institute has actively supported twenty-six cancer studies at various universities and no less than fifty people have been engaged in these investigations.

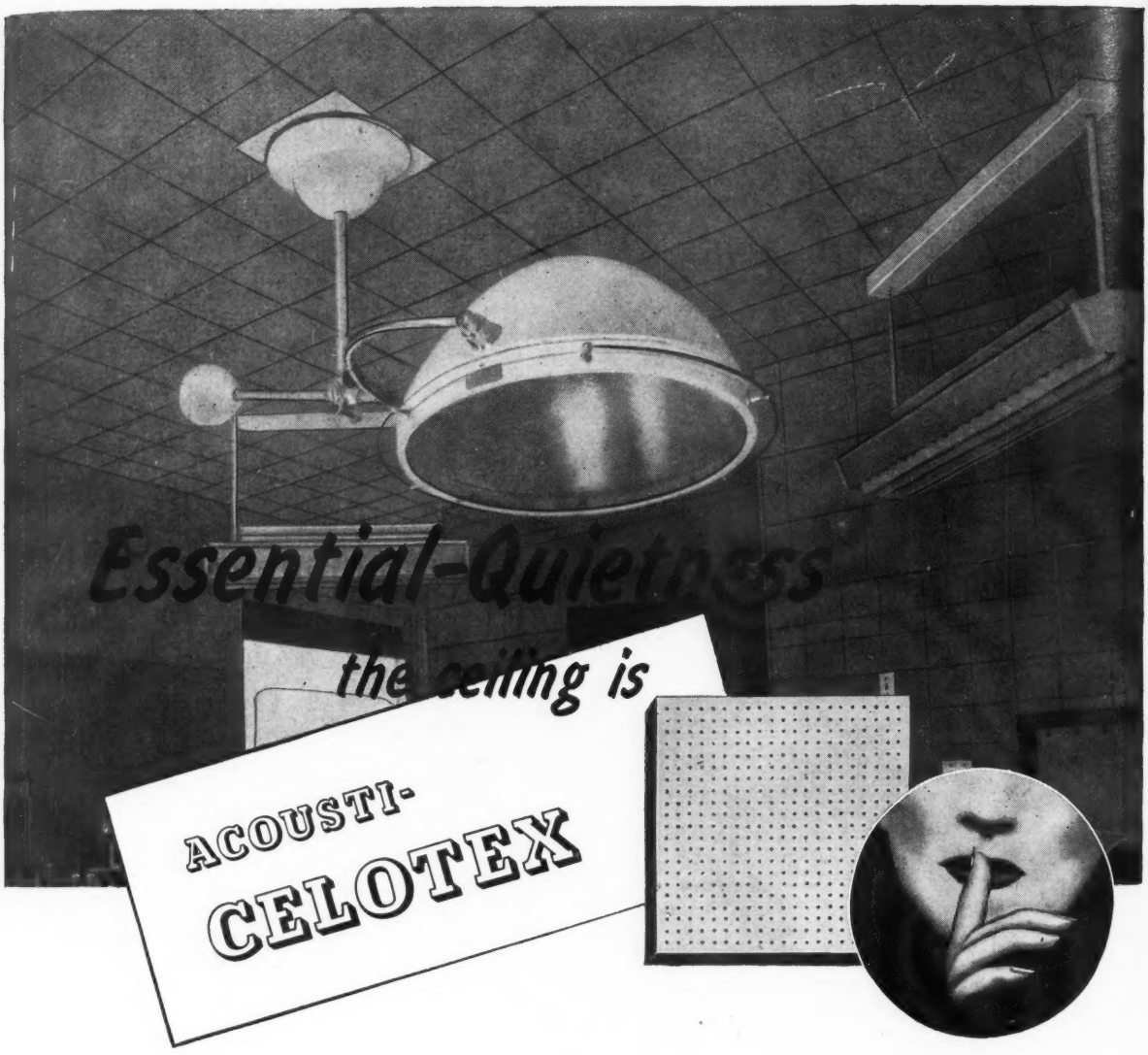
An exhaustive cancer survey has been carried out by Dr. A. W. Blair of Regina. Data concerning present cancer facilities in the provinces is being assembled and the report may be instrumental in shaping an overall program of cancer treatment in Canada.

Careful thought is being given to the establishment in Canada of a central tumour registry and a mouse-breeding colony. The Institute has been actively furthering a proposal to make cancer a reportable disease with comparable reporting systems within the provinces.

World Health Organization Now a United Nations Agency

Last month the World Health Organization attained official status as a specialized agency of the United Nations. The organization had been operating as an interim commission since July, 1946, awaiting the ratification of its charter by 26 members of the United Nations. The required number of ratifications was achieved when the Soviet Ukraine, Mexico and White Russia signified their approval, bringing the number up to twenty-seven.

Dr. G. B. Chisholm of Canada is director-general of the World Health Organization.



Not only in operating rooms but corridors, bedrooms, kitchens, etc., noise is a detriment in any hospital. Eliminate it by having all ceilings covered with ACOUSTI-CELOTEX tile. Noise is hushed where it is applied.

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Radio Interference Discussed at Ottawa

On March 18th Mr. Stanley Knowles (Winnipeg North Centre) directed a question to the Minister of Trade and Commerce in the House of Commons as to whether the government had given consideration to the request of the Canadian Hospital Council for a change in the regulations respecting radio interference by electrotherapeutic equipment and, if so, what was the result. The Rt. Hon. C. D. Howe indicated that he would obtain the answer and give a reply shortly.

The question arose again on March 22nd when the Rt. Hon. Mr. Howe spoke as follows:

"The answer to the first part of the question is, yes. Consideration has been given to the request of the Canadian Hospital Council. The answer to the second part of the question is that the regulations in question were passed by order-in-council on January 22, 1941, to be effective on February 8, 1941. The application of these, insofar as electrotherapeutic equipment is concerned, was postponed nearly seven years to January 1, 1948, owing to a shortage of supply of material and equipment. The question of a further postponement has now undoubtedly been raised by reason of action in the United States where a five-year period of grace has been given. It will be noted that the similar period of grace in Canada has been seven years. There is an outstanding difference, however, in the interference caused by this equipment in the two countries. In the United States a large part of transmitting equipment is very high powered and is not affected to as great an extent as in Canada, where the greater part is of a much lower power.

"Interference by the operation of this equipment is a serious matter in radio communications in Canada unless adequate means are employed to control the radiation. Safety radio services, such as aids to air and marine navigation, police and fire department radio, are frequently blotted out by radiation from diathermy machines at distances of hundreds of miles. A further period of grace in this matter of suppressing this type of interference would delay the proper development of these and other high frequency services.

"While it is proposed therefore to enforce the regulations effective January 1, 1948, I would point out that the inspectors of the radio branch of the Department of Transport have done nothing to disrupt existing operations where interference is not being encountered. However, where interference is found, operators of this type of equipment will be required to install the necessary shielding if the equipment is to continue to be operated."

Execution in the Palace

Among the records preserved in the College of Pestology (52 Bedford Square, London, England) is a receipt for two guineas paid in July 1827, to the Bug-Destroyer to His Majesty King George IV, for destroying bugs in four bedsteads.

—*A.S.*

The Auxiliaries

Aid Will Refurnish Hospital Ward

Plans are being made by the Women's Auxiliary to refurnish and redecorate the soldiers' ward at the Victoria Hospital at Renfrew, Ontario. All furnishings will be new and as attractive as possible.

It was announced that the group will now become affiliated with the Provincial Board of Auxiliaries.

* * * *

Hospital Aid at Midland Reports Successful Year

St. Andrew's Hospital Auxiliary, Midland, Ontario, reported a busy and successful year at their annual meeting held recently. Regular meetings are held each month and there is now an active membership of 64, an increase of 14 over the previous year.

Each year the auxiliary undertakes to keep the hospital linen cupboard well supplied, but a large balance from 1946 permitted the purchase of several pieces of hospital equipment, including a food conveyor, incubator, stretcher and mattress, toasters, trays, food covers and bed tables.

Further plans were discussed at the meeting for raising money to continue the activities of this busy group. Mrs. R. G. Gillies is president for the year.

* * * *

Excellent Luncheon Arrangements Provided for Institute

A feature of the arrangements for the Institute for Hospital Administrators, held in London in April, was the set-up for the daily luncheons. The Ladies' Auxiliary of Victoria Hospital undertook to provide luncheons for all, in the assembly room at the nurses' residence, next door to the Medical College. Teams of Women's Auxiliary members prepared the meals and waited on the tables each day. This arrangement was much appreciated by the more than one hundred registrants who, otherwise, would have found it necessary to go back to the hotel district during the lunch hour.

Mrs. H. S. Fletcher is President of the Ladies' Auxiliary and Mrs. L. S. Norwood is convener of the hospital *Tea Shoppe* committee which was directly in charge.

* * * *

Grace Hospital Aid in Winnipeg Holds Fifteenth Annual Meeting

At the annual meeting of the Grace Hospital Ladies' Auxiliary held last month, Mrs. W. C. Barton was re-elected president. It was the 15th anniversary of the auxiliary. In giving a resume of the activities of the auxiliary over this period, Mrs. W. T. Lowe announced that the sum of $5,005.13 had been raised, which had been used to furnish the nurses' dining room and sitting room in the nurses' residence. The main project was to furnish a private ward in the surgical wing.

Brigadier Payton, superintendent of the hospital, thanked members for their practical aid throughout the fifteen years, and praised members for support of their projects. "It is important" she said, "to band together and stand for things that bring peace and a better way of life for all."

Physical Medicine in D.V.A. Hospitals

The purpose of physical medicine is to make a patient physically and mentally fit for gainful employment in the shortest possible time. Its scope has been enlarged to include pre-vocational guidance and screening. Close co-ordination with the Rehabilitation Branch (D.V.A.) in shaping the patients' vocational goal has been achieved by weekly staff meetings of doctors, occupational and physiotherapists, supervisors of training and casualty rehabilitation officers, since teamwork is of the utmost importance.

The modalities employed in both the active treatment hospitals and the Health and Occupational Centres consist of physiotherapy, occupational therapy, remedial physical training, workshops, planned recreation, institutional training and arts and crafts. These are prescribed and co-ordinated on the basis of the examination of the individual case. Physical medicine commences in the active treatment hospitals with bed exercises, then progresses to the physiotherapy and occupational therapy departments. Institutional training is carried on concurrently when indicated. Co-ordination and continuity of treatment between the active treatment hospitals and Health and Occupational Centres has been stressed and is being constantly checked....

Institutional training has been carried on in all active treatment hospitals, Health and Occupational Centres and tuberculosis sanatoria by personnel supplied by the Rehabilitation Branch. The scope of the work comprises correspondence courses, lectures, directed reading and other forms of educational or pre-vocational training. In the Health and Occupational Centres, short practical workshop courses are presented, in addition to the theory courses. The object of these is to assess the patient's aptitudes and form a judgment of his vocational capabilities, thus making it possible to direct the patient into other fields of activities should he not be fitted the particular one attempted.

—From an article by T. H. Coffey, M.D., in the D.V.A. "Treatment Services Bulletin."

God created man in his image, and man has not been slow in returning the compliment. *—Heine.*

Provincial Notes

(Concluded from page 64)

SIOUX LOOKOUT. It is planned to build two new hospitals in Sioux Lookout this year. Tenders for the construction of a $225,000 general hospital will be invited at an early date. Also, a new 50 to 65 bed Indian hospital is planned by the Indian Health Services, D.N.H. & W.

* * * *

SUDBURY. Last month the first sod was turned for the new Sudbury General Hospital, when Hon. Ray Lawson, Lieutenant-Governor of Ontario, officiated. The new building will cost $1,750,000 and will be one of the most modern in the Dominion. All services will be centralized and even ambulances will ascend a ramp to the third floor where operating and obstetrical rooms will be located.

On completion the new hospital will be administered by the Sisters of St. Joseph.

* * * *

WINDSOR. Grace Hospital is planning to spend $350,000 this year for the purchase of equipment and the addition of new operating and x-ray rooms. Five homes, now used to house student nurses, will be torn down and a new nurses' residence erected to accommodate 125 staff members.

Quebec

MONTREAL. Dr. John de Belle, general superintendent of the Children's Memorial Hospital, said recently that local hospital accommodation for the treatment of children is past the danger stage and that the situation is now critical. He drew attention to the fact that on one week-end alone, it was necessary for his institution to refuse admission to 12 children who needed hospitalization. At present the Children's Memorial Hospital has a waiting list of over 1,500 children.

* * * *

MONTREAL. The resignation is announced of Miss Dorothy MacRae, superintendent of nurses of the Herbert Reddy Memorial Hospital. She will be succeeded by Miss Helen Gertrude Hewton.

New Brunswick

SUSSEX. The new 50-bed Kings County Memorial Hospital was opened recently at Camp Sussex. The building is the former military hospital, and was acquired by the hospital committee when it was no longer required for veterans.

The old wards have been reconstructed into private and semi-private rooms, contagious wards, and an obstetrical section. Thirty-five beds are ready for use and the remaining fifteen will be set up as required.

Nova Scotia

HALIFAX. The Hon. F. R. Davis, M.D., Minister of Health, has confirmed in the legislature that negotiations are going forward for a lease by the province of the Navy Hospital at Point Edward. It is planned to use this building for the care of tuberculous patients, thus helping to meet the need for more sanatorium beds. He indicated that acquisition of the hospital could be on a lease basis only as the navy might wish to take it over again in case of any "emergency".

Hospital Records are of Vital Importance

One of the most important purposes for which the medical case record is kept is for group study, for it is by such study that medical knowledge grows. If records are to be used for group studies of disease, the lack of important information constitutes a serious handicap and might even make an accurate study impossible. It is not at all flattering to a hospital to check records of some obscure disease, only to discover that though several cases were treated, nothing can be learned because of the lack of vital data. In hospitals where research work is encouraged, there is a notable improvement in the quality of records, for one result of research itself is the recognition of the value of reliable case histories. So, although the statistical side of surgical and medical procedures may be quite irksome to many of us, and especially to those who have felt bound with the red tape of the Services, it should be remembered that hospitals are judged partially by their records and reports, and that we owe it to ourselves, as well as to others concerned, to render as competent a service on our "paper work" as we automatically extend in the exercise of our technical skill.

The golden rule is actually the truest hypothesis for science as well as for civilization, and we must be ever cognizant of the fact that the greatest number of people are unborn. Consequently, in our obligation to them, we must not, we cannot waste or destroy present findings which may affect their future.

Adequate medical records are twicefold more meaningful today than they were yesterday and our appreciation of this grows with the advancement of medical science. Who today knows what scientific data, which may seem minor at this time, will become a record of great value, perhaps serving as the element on which is based an entirely new and rewarding contribution to the well-being of humanity!—*Brig. Wallace H. Graham, M.D., Washington, D.C.*

The happiest part of a man's life is what he passes lying awake in bed in the morning.

—*Samuel Johnson.*

◀ Book Reviews ▶

(Concluded from page 62)

most commendable because the lay-out of the pages makes a difficult subject as easy to read as is possible. The latest edition of Bower and Pilant should be made available to all student nurses.

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NURSING HISTORY. By Minnie Goodnow, R.N., author of the Technic of Nursing and of Nursing History in Brief. 8th edition. Pp. 404. Illustrated. Price $3.85. W. B. Saunders Company, Philadelphia and London, 1948. Canadian agents, McAinsh & Co. Limited, Toronto.

In presenting the eighth edition of this book, the editor has done so with a view to keeping the volume as up-to-date and complete as possible. First published in 1916, and revised about every four years since, the book offers an excellent source of information on the history of nursing throughout the years. Much of the older material has been condensed and a great deal of new material added, including nearly fifty illustrations.

Beginning with a chapter on nursing in ancient times, it covers the various periods up to the present day. Several chapters are devoted to the development of nursing in other countries and the difficulties which were encountered in the attempt to expand nursing services.

With the present-day rapid communication, increasing travel, and expanding economic relations with the whole world, it is important that the nurse keep abreast of developments in other countries, and this most recent edition offers much concentrated information.

Manitoba Tuberculosis Death Rate Drops

At the annual meeting of the Sanatorium Board of Manitoba, Dr. E. L. Ross, medical director, reported a drop in deaths from tuberculosis in Manitoba from 322 in 1946 to 264 in 1947 and examination by the tuberculosis clinics, including surveys, in the province of 276,839 people (more than double the 1946 figure).

Dr. Ross said that during the last 20 years tuberculosis deaths have dropped from 375 to 264, a reduction in the rate per 100,000 population from 57.6 to 36.7. The improvement is even more striking for the white population alone, showing a decline in the death rate from 50.1 to 21.9 per 100,000 population.

Although the tuberculosis death rate of the Manitoba Indians is still 30 times the white death rate, it has been decidedly reduced in the past three years.

In 1947, 1,686 new cases of tuberculosis were diagnosed, compared to 1,187 in 1946, but it was pointed out that the increase of 499 is due to the larger number of both whites and Indians x-rayed by mass surveys.

The report announced that for the Indians "a program of case finding, segregation and treatment, comparable to that for white people, has been launched".

The Direct Approach

Polish hospitals once issued chloroformed pyjamas to insomnia patients.

Co-ordinating Mental Hygiene Programs

Our prospects in Canada for the strengthening of mental hygiene work are not only enhanced by our policy of partnership with public health, but also by the trend that is developing in this country of co-ordinating therapeutic and preventive mental hygiene activities into one integrated program. In adopting this plan we are breaking away from the traditions of the past, wherein there was little interplay between the activities of mental hospitals, of mental hygiene clinics and of positive mental health programs in health units and in schools. Each one of these activities suffered when they were deprived of the opportunity for close collaboration. Mental hospitals, for example, were left in a state of isolation, and this is one reason why these institutions have experienced great difficulty in recruiting staffs, in improving the efficacy of their services, and in winning the confidence of the public. Such isolation of the mental hospitals is unwarranted because members of the staffs of these institutions are eager to participate, on a part-time basis, in community programs and they have much to contribute in this regard. And it should be borne in mind that if these mental hospital staffs are not given an opportunity to share in community work, there is the tendency for the staffs themselves to deteriorate. They lose a sense of perspective in their work. Like their patients, they become institutionalized and the efficiency of the hospitals with which they are connected, is placed in jeopardy.

Now the plan of co-ordinating mental hygiene efforts has been instituted in several of our Canadian provinces. In one Western province, the mental hospitals have assumed the responsibility of providing training-courses in mental hygiene for public health nurses, for social workers and for school teachers. These hospitals, in collaboration with clinics, furnish training for these community workers in history-taking, in the gaining of an understanding of mental hygiene principles and in actual participation in the treatment of maladjusted individuals. As a result of their training, these community workers return to their respective jobs better equipped for their tasks and more alert to play their part in mental health conservation. The mental hospitals, by furnishing this training service, in addition to the meeting of other obligations, are placed in a position of energizing community mental health programs and of being viewed by the public, not as custodial asylums but as centres for mental health endeavour with great possibilities for contributions in the public health field.

—Clarence Hincks, M.D., in "Canadian Journal of Public Health".

Secretary-Treasurer of RNAO Retires After 21 Years Service

After twenty-one years of service as secretary-treasurer of the Registered Nurses' Association of Ontario, Miss Matilda E. Fitzgerald announced her retirement from this position at the annual meeting held in Toronto last month. Miss Fitzgerald's retirement will take effect at the end of the current fiscal year. Tribute to her devoted service and leadership, which assisted so greatly in the growth of the association, was expressed in a resolution. Miss Nettie D. Fidler was re-elected president.

It was decided that the next annual meeting of the RNAO will be held in Ottawa during Easter week, 1949.

Health Through Education

The tide of social change is rising and nursing education, by virtue of its social and economic characteristics, must go with the tide if it is to realize the purpose of its being. Hitherto, nursing was concerned with curative methods and the hospital was the limited field of activity. Now the accent is on the prevention of disease. This is made possible by social legislation. However, a glance at the present-day curriculum in the average school of nursing reveals that little provision is made to prepare the professional nurse to meet this new concept of health. Short courses in the social sciences would make a valuable contribution here.

We are all aware of the rapid growth in the field of public health and that every province in the dominion is more or less actively engaged in plans for even larger projects of this nature. The future promises every community its own health centre from which nursing services will be dispensed but the emphasis will be on the promotion of positive health through education. It would be interesting to know how many schools of nursing are preparing their students to meet this community need, how many students will graduate with a real understanding of the many nationalities, religions, traditions and economic levels that make up the average rural community. A short but comprehensive course in sociology would enable the nurse to meet this situation with a better understanding, and so give a more worthwhile contribution to the health program of the future.

—M. Kathleen Ruane, Reg.N.

Aids to Better Laundering

Polyphosphates are being used as aids to better washing by an increasing number of laundries. "Poly" means "many", and phosphates are made from the same chemical building blocks that are found in certain common alkalies.

By varying the composition, different phosphates can be produced, and by changing the heat treatment very different materials can be made from the same ingredients used in the same proportions.

Sodium tetraphosphate not only softens water without forming sludge or scum, but also dissolves lime soap. Soap is destroyed by acid soil, but can be protected by an alkaline builder. Hard water wastes soap and builds up lime soap on goods and wheels, but zeolite water softeners aid in reducing the amount of hardness in water.

Starting with water of zero hardness and running the wheel just long enough to wet out the load completely, water has been tested at five to seven grains per gallon hardness. This means that with an average load, about one pound of soap will be wasted in softening the water. Loss of soap cannot be prevented by the use of alkali. For complete softening with alkali, it is necessary to filter out the sludge. If this is not done, soap will continue to be lost because lime soap is less soluble than the lime salts of alkali.

Sodium tetraphosphate will soften water so completely without the formation of sludge that no soap will be wasted. The phosphate costs less than soap and less quantity is used.

Of particular importance to launderers is the fact that a fabric containing lime soap is rough and harsh. Sheets and towels having this "sandpaper" finish are intensely disliked and such linens are dangerous to patients because constant abrasion of the skin is likely to cause rash or actual lesions. It has also been proved that bacteria can live for long periods in lime soap. Another objection to the use of lime soap is its bad odour resembling that of rancid grease. This can often be eliminated quickly by a thorough treatment with polyphosphate.

If the lime soap has been deposited in previous launderings the residue may be dissolved by using sodium tetraphosphate in any normal washing formula without other special treatment.

The use of polyphosphate increases whiteness retention to such an extent that it is often possible to reduce the amount of bleach by 50 per cent. Softness of finish and smoothness of texture are also improved. The added softness is produced by the ability of the tetraphosphate to dissolve and remove the deposit of lime soap and dirt. When the cloth is freed from these "residuals", both starch and blue penetrate better and are absorbed more evenly, producing a whiter and softer finish.

—Arthur Razee in "The Laundryman", Hospital Abstract Service.

Business is really more agreeable than pleasure; it interests the whole mind, the aggregate nature of man more continuously and more deeply. But it does not *look* as if it did.

—Walter Bagehot.

Chronics as a Major Problem

Each year the problem of the aged and their ills will demand more time and attention from health departments, physicians and hospitals. There seems to be three main aspects to the situation. First, further research and the application of preventive measures for diseases more commonly found in this age group. Secondly, a wider application of therapeutics, including rehabilitation efforts for patients in this category. This may mean more hospital days and an increase in some types of service offered by a hospital. Whether such treatment should be done on the wards of the existing general hospitals or in special institutions may be a matter of argument. Thirdly, the time will come for some of these patients, when provision must be made for permanent care. Many such patients either have no home or lack the facilities therein; consequently, some type of institution must be prepared to give the necessary care.

Very few general hospitals are organized for the purpose of providing permanent care in addition to care required for acute illness. When the chronic patient who needs permanent care is ready for discharge, a disposal problem is created unless transfer to a suitable institution can be made immediately. This is the point at which our existing general hospitals become acutely aware of the problem associated with the patient who is going to require permanent, or very prolonged nursing care. Complete information on the extent of this situation in the Manitoba hospitals is not available, but we do know that in 1945, 33 out of 39 general hospitals had public ward patients over a three months' period. These patients accounted for 10.5 per cent of the public ward days in those hospitals concerned. The "three months" patients discharged during 1945 had an average stay of 130 days. Supposing they had been discharged at the end of the three month period, the hospitals concerned could have admitted an additional 850 patients for an average ten days stay.

The problem of the chronically ill, especially those in the older age groups who need permanent care, is becoming increasingly noticeable each year insofar as hospitals are concerned. These patients must receive care and if any thought is to be given to the possibility of integrating this type of care into a hospital scheme for a community, then the thinking concerning over-all bed requirements may need some revision.

—C. R. Donovan, M.D., Department of Public Health, Manitoba.

An Ill Wind . . .

A strike called by AFL Food Warehousemen resulted in the closing of more than 100 stores of the Kroger Grocery chain in Western Pennsylvania and surrounding areas in adjoining States.

To prevent disaster to perishable goods, management ordered such stocks to be sold at cost to charitable and other institutions, including hospitals. Striking employees aided in that program.

—New Bulletin of the Penn. Hospital Association.

Coming Conventions

May 21-22—Canadian Society of Laboratory Technologists, McMaster University, Hamilton.

May 24-28—A.H.A. First Institute for Hospital Engineers, Knickerbocker Hotel, Chicago.

May 31-June 4—A.H.A. Institute on Public Relations, Westminster Choir College, Princeton University, Princeton, N.J.

June 8-12—A.H.A. Institute for Medical Record Librarians, Duke University, Durham, N.C.

June 15—Maritime Conference C.H.A. meeting.

June 16-18—Maritime Hospital Association, Algonquin Hotel, St. Andrews, N.B.

June 17-19—Canadian Society of Radiological Technicians, Chateau Frontenac, Quebec City.

June 21-25—Canadian Medical Association, Royal York Hotel, Toronto.

June 28-July 1—Canadian Nurses Association, Mount Allison University, Sackville, N.B.

September 6-18—A.C.H.A. Institute for Hospital Administrators, Chicago.

September 18-19—American College of Hospital Administrators, Traymore Hotel, Atlantic City.

September 20-23—American Hospital Association. Atlantic City Convention Hall, Atlantic City.

Week of Oct. 4th—Western Institute for Hospital Administrators, Hotel Vancouver, Vancouver.

Oct. 14-15—Saskatchewan Hospital Association, Saskatchewan Hotel, Regina.

Oct. 18-22—A.C.S. Clinical Congress, Biltmore Hotel, Los Angeles.

November 1-3—Ontario Hospital Association, Royal York Hotel, Toronto.

Nov. 8-10—Associated Hospitals of Alberta, Palliser Hotel, Calgary (changed from 10-12).

Notes on Margarine

(Concluded from page 54)

print a notice of this practice on the menu or on a conspicuous sign. The hospital which fails to do so may have to pay a $50 fine for the first offence.

In 23 states the sale of coloured margarine is forbidden. Seventeen states prohibit or restrict its use in state institutions. Eight states add their own taxes and fees on margarine to those imposed by the federal government. These taxes are levied on commercial eating places and charitable institutions alike.

We go to our favourite classical author, as it were for conversation with a friend; and we discover that these benevolent antique minds reflect our own thoughts, but in richer maturity. Their friendship never fails us, and their serene philosophy brings us reconciliation—and how often do we need it!—with mankind and with ourselves.

—*Sainte-Beuve.*

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